# Summary Plan Description

**IACT Medical Trust**
**Plan D**

Effective: January 1, 2015
Group Number: 743402

UnitedHealthcare®
Healing health care. Together.®

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# SECTION 1 - WELCOME

**Quick Reference Box**

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (866) 844-4864;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, UT 84130-0555; and
- Online assistance: **www.myuhc.com**.

IACT Medical Trust is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

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

IACT Medical Trust intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. IACT Medical Trust is solely responsible for paying Benefits described in this SPD.

Your coverage is issued by a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for your multiple employer welfare arrangement.

Notwithstanding any other provision in this SPD, the Plan is intended to comply with the MEWA Final Rule promulgated by the Indiana Department of Insurance (760 IAC 1-68-1 *et seq.*). The Plan provides Benefits in accordance with the minimum requirements set forth in the MEWA Final Rule as interpreted in the sole discretion of the Plan Administrator.

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact the Human Resources Department or call the number on the back of your ID card.

**How To Use This SPD**

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can request copies of your SPD and any future amendments by contacting the Human Resources Department.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- IACT Medical Trust is also referred to as the Trust.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

# SECTION 2 - INTRODUCTION

**What this section includes:**

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

## Eligibility

You are eligible to enroll in the Plan if you are a regular full-time Participant as defined by the Municipality or a person who retires while covered under the Plan and meets eligibility criteria as defined by the Municipality.

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

- a Participant's Spouse, as defined in Section 14, *Glossary*;
- a Participant's natural child, legally adopted child or a child for adoption with the Participant who is less than 26 years of age;
- a Participant's stepchild, grandchild, blood relative, or a child whom legal guardianship has been awarded to the Participant or the Participant's Spouse, who is less than 26 years of age**;**
- a Participant's natural child, stepchild, legally adopted child, a child placed for adoption with the Participant or a child for whom legal guardianship has been awarded to the Participant or the Participant's Spouse who is 26 years of age or older, but less than 27 years of age only if you furnish evidence upon request, satisfactory to the Plan, of all of the following conditions:
  - the individual is not regularly employed on a full-time basis;
  - the individual is a Full-time Student, as defined in Section 14, *Glossary*; and
  - the individual is primarily dependent on the Participant for support and maintenance.
- a Participant's natural child, stepchild, legally adopted child or child who is placed for adoption with the Participant, or a child for whom legal guardianship has been awarded to the Participant or the Participant's Spouse who is any age and who is or becomes disabled and dependent upon the Participant.

An individual who meets the requirements set forth above ceases to be eligible as a Dependent on the last day of the year in which the individual reaches the limiting age.

The Participant must reimburse the Plan for any Benefits that were paid at a time when the individual did not satisfy these conditions.

A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

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, as described in Section 13, *Other Important Information*.

## Cost of Coverage

You and the Employer 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 - and 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 Employer reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling the Human Resources Department.

## How to Enroll

To enroll, call the Human Resources Department 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. Any changes you make during Open Enrollment will become effective the following January 1.

**Important**
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Human Resources Department within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

## When Coverage Begins

Once the Human Resources Department receives your properly completed enrollment, coverage will begin on your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the date of your marriage, provided you notify the Human Resources Department within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify the Human Resources Department within 31 days of the birth, adoption, or placement.

## Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Human Resources Department within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Human Resources Department within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact the Human Resources Department within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

***Note:*** Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

***Change in Family Status - Example***

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in IACT Medical Trust's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under IACT Medical Trust's medical plan outside of annual Open Enrollment.

# SECTION 3 - HOW THE PLAN WORKS

**What this section includes:**

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Out-of-Pocket Maximum; and
- Coinsurance.

## Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. For facility services, these are Benefits for Covered Health Services that are provided at a Network facility under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. Emergency Health Services are always paid as Network Benefits.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care. Emergency services received at a non-Network Hospital are covered at the Network level.

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

### *Network Providers*

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

Network providers are independent practitioners and are not employees of IACT Medical Trust or UnitedHealthcare.

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

### *Possible Limitations on Provider Use*

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

## Eligible Expenses

IACT Medical Trust has delegated to the Claims Administrator the initial discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines that the Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the SPD.

**For Network Benefits**, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

**For Non-Network Benefits**, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
  - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.
  - If rates have not been negotiated, then one of the following amounts:
    - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
    - For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
    - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

      When a rate is not published by *CMS* for the service, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claims Administrator will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap fill relative value scale information.

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

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.

**Don't Forget Your ID Card**
Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

## Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

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

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

### Copayment

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

### Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

**Coinsurance – Example**
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

### Out-of-Pocket Maximum

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

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

| Plan Features | Applies to the Network Out-of-Pocket Maximum? | Applies to the Non-Network Out-of-Pocket Maximum? |
|---|---|---|
| Copays, even those for Covered Health Services available in Section 15, *Prescription Drugs* | Yes | Yes |
| Payments toward the Annual Deductible | Yes | Yes |
| Coinsurance Payments | Yes | Yes |
| Charges for non-Covered Health Services | No | No |
| The amounts of any reductions in Benefits you incur by not notifying Personal Health Support | No | No |
| Charges that exceed Eligible Expenses | No | No |

### *How the Plan Works - Example*

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has met his Network Annual Deductible, but not his non-Network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a Network Physician versus a non-Network Physician.

## Network Benefits

1. Gary goes to see a Network Physician, and presents his ID card.
2. He receives treatment from the Physician. The Plan's Eligible Expense for the Network office visit equals $125.
3. On his way out, Gary pays a $25 Copay. Since Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.
4. The Plan pays $100 ($125 Eligible Expense minus $25 Copay).

## Non-Network Benefits

1. Gary goes to see a non-Network Physician, and presents his ID card.
2. He receives treatment from the Physician. The Eligible Expense for his visit is $175, however the Physician's fee is $225.
3. The Physician's office requests no payment, informing Gary that it will bill UnitedHealthcare directly.*
4. Gary is responsible for paying the Eligible Expense of $175 directly to the Physician, because he has not yet met his Annual Deductible.
5. Gary receives a bill from the Physician, and pays the Physician directly.
6. The Physician's office, at its discretion, might bill Gary for the remaining $50:

| $225 | - | $175 | = | $50 |
|---|---|---|---|---|
| (Physician's fee) | | (Eligible Expense) | | |

Gary's $50 payment does not apply to his Annual Deductible or Out-of-Pocket Maximum.

7. UnitedHealthcare applies the $175 toward Gary's Annual Deductible and Out-of-Pocket Maximum.

*Although non-Network providers have the right to request payment in full at the time of service, they bill UnitedHealthcare directly in most cases.

## SECTION 4 - PERSONAL HEALTH SUPPORT

**What this section includes:**

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare 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. A Personal Health Support Nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with 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 and notification requirements are subject to change without notice. As of the publication of this SPD, the Personal Health Support program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies.

Participants may receive a phone call from a Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

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 toll-free number on your ID card.

## Requirements for Notifying Personal Health Support

Network providers are generally responsible for notifying Personal Health Support before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Personal Health Support.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying Personal Health Support before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if Personal Health Support is not notified.

The services that require Personal Health Support notification are:

- ambulance – non-emergent air and ground;
- Clinical Trials;
- Congenital Heart Disease services;
- dental services - accident only;
- Durable Medical Equipment for items that will cost more than $1,000 to purchase or rent;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay;
- maternity care that exceeds the delivery timeframes as described in Section 6*, Additional Coverage Details*;
- outpatient dialysis treatments as described in under *Therapeutic Treatments - Outpatient* in Section 6, *Additional Coverage Details*;
- Reconstructive Procedures;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- temporomandibular joint services;
- treatment of Gender Identity Disorder/dysphoria as described under *Treatment of Gender Identity Disorder/Dysphoria*, in Section 6, *Additional Coverage Details*; and
- transplantation services.

Notification is required within one business day of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For notification timeframes, and reductions in Benefits that apply if you do not notify Personal Health Support, see Section 6, *Additional Coverage Details*.

**Contacting Personal Health Support is easy.**
Simply call the toll-free number on your ID card.

## Special Note Regarding Mental Health and Substance Use Disorder Services

You must provide pre-service notification as described below. You are not required to provide pre-service notification when you seek these services from Network providers. Network providers are responsible for notifying the Mental Health/Substance Use Disorder Administrator before they provide these services to you.

When Benefits are provided for any of the services listed below, the following services require notification:

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;

- Neurobiological Disorders - Autism Spectrum Disorders Services -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management. Pre-service notification is also required for Benefits provided for Applied Behavioral Analysis (ABA); and
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be reduced to 50% of Eligible Expenses. Services requiring prior notification are:

- intensive outpatient program treatment;
- outpatient electro-convulsive treatment;
- psychological testing;
- outpatient treatment of opioid dependence;
- extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

## Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

## SECTION 5 - PLAN HIGHLIGHTS

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

| Plan Features | Network | Non-Network |
|---|---|---|
| **Copays**[1] | | |
| ■ Emergency Health Services | $175 | $175 |
| ■ Physician's Office Services | $25 | Not Applicable |
| ■ Urgent Care Center Services | $75 | Not Applicable |
| **Annual Deductible**[2] | | |
| ■ Individual | $1,000 | $2,000 |
| ■ Family (not to exceed $1,000 per Covered Person for Network Benefits and not to exceed $2,000 per Covered Person for Non-Network Benefits) | $2,000 | $4,000 |
| **Annual Out-of-Pocket Maximum**[2,3] | | |
| ■ Individual | $3,500 | $5,000 |
| ■ Family (not to exceed $3,500 per Covered Person for Network Benefits and not to exceed $5,000 per Covered Person for Non-Network Benefits) | $7,000 | $10,000 |
| **Lifetime Maximum Benefit**[4] There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. | Unlimited | |

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services, a Copay does not apply when you visit a non-Network provider.

[2]Copays do not apply toward the Annual Deductible but do apply to the Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

[3]The Annual Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.

[4]Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | **Network** | **Non-Network** |
| **Autism Spectrum Disorder** | Depending upon where the Covered Health Service is provided, Benefits for Autism Spectrum Disorder will be the same as those stated under each Covered Health Service category in this section. | |
| **Acupuncture Services**<br>(Copay is per visit)<br>Up to 6 treatments per calendar year | 100% after you pay a $25 Copay | 100% after you pay a $25 Copay |
| **Ambulance Services**<br>■ Emergency Ambulance<br>*Note:* The Network Deductible applies for Network and Non-Network Benefits<br>■ Non-Emergency Ambulance<br>*Note:* The Network Deductible applies for Network and Non-Network Benefits | 80% after you meet the Annual Deductible<br>80% after you meet the Annual Deductible | 80% after you meet the Annual Deductible<br>80% after you meet the Annual Deductible |
| **Anesthesia/Hospital Coverage for Dental Care** | Depending upon where the Covered Health Service is provided, Benefits for Anesthesia/Hospital Coverage for Dental Care will be the same as those stated under each Covered Health Service category in this section. | |
| **Cancer Resource Services (CRS)**[2]<br>■ Hospital Inpatient Stay | 80% after you meet the Annual Deductible | Not Covered |
| **Clinical Trials** | Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section. | |

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | **Network** | **Non-Network** |
| **Congenital Heart Disease (CHD) Surgeries** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Dental Services - Accident Only**<br>*Note:* The Network Deductible applies for Network and Non-Network Benefits<br>Up to $3,000 per calendar year. Benefits are further limited to a maximum of $900 per tooth. | 80% after you meet the Annual Deductible | 80% after you meet the Annual Deductible |
| **Diabetes Services**<br>■ Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care | Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section. | |
| ■ Diabetes Self-Management Items | Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 15, *Prescription Drugs*. | |
| **Durable Medical Equipment (DME)** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Emergency Health Services - Outpatient**<br>If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead. | 100% after you pay a $175 Copay | |
| **Hearing Aids**<br>Up to $5,000 per calendar year | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | **Network** | **Non-Network** |
| **Home Health Care**<br>Up to 180 visits per calendar year | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Hospice Care** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Hospital - Inpatient Stay** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Inherited Metabolic Disease Treatment** | Depending upon where the Covered Health Service is provided, Benefits for Inherited Metabolic Disease Treatment will be the same as those stated under each Covered Health Service category in this section. | |
| **Intensive Pediatric Feeding Program** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Kidney Resource Services (KRS)**<br>(These Benefits are for Covered Health Services provided through KRS only) | 80% after you meet the Annual Deductible | Not Covered |
| **Lab, X-Ray and Diagnostics - Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Mental Health Services** | | |
| ■ Hospital - Inpatient Stay | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| ■ Physician's Office Services (Copay is per visit) | 100% after you pay a $25 Copay | 60% after you meet the Annual Deductible |

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | Network | Non-Network |
| **Neurobiological Disorders - Autism Spectrum Disorders Services** | | |
| ■ Hospital - Inpatient Stay | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| ■ Physician's Office Services (Copay is per visit) | 100% after you pay a $25 Copay | 60% after you meet the Annual Deductible |
| **Nutritional Counseling**<br>(Copay is per visit) | 100% after you pay a $25 Copay | 60% after you meet the Annual Deductible |
| **Orthotic Device and Prosthetic Devices - Artificial Arms, Legs, Feet and Hands** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Ostomy Supplies** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Pharmaceutical Products - Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Physician Fees for Surgical and Medical Services** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Physician's Office Services - Sickness and Injury** | | |
| ■ Office Visits (Copay is per visit) | 100% after you pay a $25 Copay | 60% after you meet the Annual Deductible |
| ■ Home Visits | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | **Network** | **Non-Network** |
| **Podiatry**<br>(Copay is per visit)<br>Up to $750 per calendar year | 100% after you pay a $25 Copay | 60% after you meet the Annual Deductible |
| **Pregnancy – Maternity Services**<br>A 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. | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. | |
| **Preventive Care Services** | | |
| ■ Physician Office Services | 100% | Not Covered |
| ■ Lab, X-ray or Other Preventive Tests | 100% | Not Covered |
| ■ Breast Pumps | 100% | Not Covered |
| **Prosthetic Devices** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Reconstructive Procedures** | | |
| ■ Physician's Office Services | 100% after you pay a $25 Copay | 60% after you meet the Annual Deductible |
| ■ Hospital - Inpatient Stay | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| ■ Physician Fees for Surgical and Medical Services | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| ■ Prosthetic Devices | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| ■ Surgery - Outpatient | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | **Network** | **Non-Network** |
| **Rehabilitation Services - Outpatient Therapy and Manipulative Treatment**<br>(Copay is per visit)<br>See Section 6, *Additional Coverage Details*, for visit limits | 100% after you pay a $25 Copay | 60% after you meet the Annual Deductible |
| **Scopic Procedures - Outpatient Diagnostic and Therapeutic** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Skilled Nursing Facility/Inpatient Rehabilitation Facility Services**<br>Up to 180 days per calendar year | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Substance Use Disorder Services**<br>■ Hospital - Inpatient Stay<br>■ Physician's Office Services (Copay is per visit) | 80% after you meet the Annual Deductible<br>100% after you pay a $25 Copay | 60% after you meet the Annual Deductible<br>60% after you meet the Annual Deductible |
| **Surgery - Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Temporomandibular Joint (TMJ) Services**<br>Up to $500 per calendar year | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Therapeutic Treatments - Outpatient** | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |
| **Transplantation Services**<br>Up to $30,000 per transplant for Non-Network Benefits | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |

| Covered Health Services[1] | Percentage of Eligible Expenses Payable by the Plan: | |
|---|---|---|
| | **Network** | **Non-Network** |
| **Travel and Lodging**<br>(If services rendered by a Designated Facility) | For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures | |
| **Treatment of Gender Identity Disorder/Dysphoria** | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. | Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. |
| **Urgent Care Center Services**<br>(Copay is per visit) | 100% after you pay a $75 Copay | 60% after you meet the Annual Deductible |
| **Vision Examinations**<br>(Copay is per visit)<br>Up to one exam every two calendar years | 100% after you pay a $25 Copay | Not Covered |
| **Wigs**<br>Up to $300 per calendar year | 80% after you meet the Annual Deductible | 60% after you meet the Annual Deductible |

[1]You must notify Personal Health Support, as described in Section 4, *Personal Health Support* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Personal Health Support before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

[2]These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury, Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic* Lab, *X-Ray and Diagnostics – Outpatient*, and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

# SECTION 6 - ADDITIONAL COVERAGE DETAILS

**What this section includes:**

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

## Autism Spectrum Disorder

Benefits are provided for services that are provided in connection with the treatment plan for Autism Spectrum Disorders, when prescribed by a treating Physician, even if the service would otherwise be excluded or limited when provided for any other Sickness, Injury or condition.

For purposes of this benefit "Autism Spectrum Disorder" means a neurological condition, including but not limited to Asperger's syndrome Autism, Rhett's Syndrome, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS) as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*.

The treatment of Autism Spectrum Disorder includes:

- physical therapy;
- occupational therapy;
- speech therapy;
- Applied Behavioral Analysis (ABA); and
- sensory integration therapy.

## Acupuncture Services

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

- Doctor of Medicine;

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

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

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

Any combination of Network Benefits and Non-Network Benefits is limited to 6 treatments per calendar year.

## Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

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

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

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

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must notify Personal Health Support for non-Emergency ambulance services as soon as possible prior to transport. If Personal Health Support is not notified, you will be responsible for paying all charges and no Benefits will be paid.

## Anesthesia/Hospital Coverage for Dental Care

Benefits are provided for anesthesia and Hospital charges for dental care for a child under the age of 19 or an individual with a disability who has a physical or mental impairment that substantially limits one or more of their major life activities, if the mental or physical

condition requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

The Plan will use the *Indications for General Anesthesia* published in the reference manual of the *American Academy of Pediatric Dentistry* to support any dental treatment and use of anesthesia.

## Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.urncrs.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

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

***Note:*** The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

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

## Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below; and
- other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

- Routine patient care costs for qualifying clinical trials include:
- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain Category B devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

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

Please remember for Non-Network Benefits, you must notify Personal Health Support as soon as the possibility of participation in a clinical trial arises. If Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Congenital Heart Disease (CHD) Surgeries

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

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

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

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

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

Please remember for Non-Network Benefits, you must notify United Resource Networks or Personal Health Support as soon as CHD is suspected or diagnosed. If United Resource Networks or Personal Health Support is not notified, Benefits for Covered Health Services will be reduced to 50% of Eligible Expenses.

***Note:*** The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

## Dental Services - Accident Only

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

- treatment is necessary because of accidental damage;

- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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

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

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

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

Any combination of Network Benefits and Non-Network Benefits is limited to $3,000 per calendar year. Benefits are further limited to $900 per tooth.

Please remember that you should notify Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, Personal Health Support can determine whether the service is a Covered Health Service. If Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

| Covered Diabetes Services | |
|---|---|
| Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care | Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.<br><br>Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes. |
| Diabetic Self-Management Items | Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section.<br><br>Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Prescription Drugs*. Diabetic supplies and medications covered under the Pharmacy benefit are also covered. |
| | Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under *Durable Medical Equipment* in this section. |

Please remember for Non-Network Benefits, you must notify Personal Health Support before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the purchase, rental, repair or replacement of DME will cost more than $1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies. If Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Durable Medical Equipment (DME)

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

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

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit. If you rent or purchase a piece of Durable Medical Equipment that exceeds this guideline, you may be responsible for any cost difference between the piece you rent or purchase and the piece UnitedHealthcare has determined is the most Cost-Effective.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- foot orthotics if custom molded and prescribed by a Physician;
- urinary catheters and related supplies;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Orthotic Devices and Prosthetic Devices - Artificial Arms, Legs, Feet and Hands* in this section. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

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

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

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

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

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

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

Please remember for Non-Network Benefits, you must notify Personal Health Support if the purchase, rental, repair or replacement of DME will cost more than $1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies. If Personal Health Support is not notified, you will be responsible for paying all charges and no Benefits will be paid.

## Emergency Health Services - Outpatient

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

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

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

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

Please remember for Non-Network Benefits, you must notify Personal Health Support within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. If Personal Health Support is not notified, Benefits for the Inpatient Hospital Stay will be reduced to 50% of Eligible Expenses.

## Hearing Aids

The Plan pays Benefits for 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). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to $5,000 per calendar year. This limit includes the hearing aid and any associated hearing testing.

## Home Health Care

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

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, intermittent schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

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

Any combination of Network Benefits and Non-Network Benefits is limited to 180 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Please remember for Non-Network Benefits, you must notify Personal Health Support five business days before receiving services or as soon as reasonably possible. If Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Hospice Care

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

Please remember for Non-Network Benefits, you must notify Personal Health Support five business days before receiving services. If Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

## Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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

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

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

Please remember for Non-Network Benefits, you must:
■ notify Personal Health Support for elective admissions: five business days before admission or as soon as reasonably possible;
■ notify Personal Health Support for non-elective admissions (or admissions resulting from an Emergency): as soon as is reasonably possible.
If Personal Health Support is not notified (or Personal Health Support is not notified for a non-elective admission), Benefits will be reduced to 50% of Eligible Expenses.

### Inherited Metabolic Disease Treatment

Benefits are provided for Medical Foods that are prescribed by a Physician for the treatment of Inherited Metabolic Disease.

**What is Coinsurance?**
Coinsurance is the amount you pay for a Covered Health Service, not including the Copay and/or the Deductible.

For example, if the Plan pays 80% of Eligible Expenses for care received from a Network provider, your Coinsurance is 20%.

### Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self-refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or
- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;

- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

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

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

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include, but are not limited to:

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

Benefits under this section include:

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

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

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

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

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

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

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

## Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

### *Special Mental Health Programs and Services*

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

## Neurobiological Disorders - Autism Spectrum Disorders Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders (otherwise known as neurodevelopmental disorders) that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others or property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available as described under the *Enhanced Autism Spectrum Disorders* benefit below.

Benefits include the following services provided on either an outpatient or inpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

Covered Health Services include enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

## Nutritional Counseling

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

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

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

**Protocol for initiation of multi-disciplinary intensive pediatric feeding program:**

Benefits for an inpatient and outpatient, multi-disciplinary, pediatric feeding disorders program are available to **infants and children under three years of age who meet ALL of the following requirements:**

- Have had corrective surgery for a physical defect that prevented normal enteral nutrition but who refuse to eat **following corrective surgery**. The following are examples of qualifying conditions (this list is not all inclusive):
  - gastroesophageal reflux disease;
  - gastrointestinal motility disorders;
  - cleft palate;
  - tracheo-esophageal fistula;
  - gastrostomy tube dependence;
  - nasogastric feeding tube dependence; **AND**

- Have failed outpatient treatment by a multidisciplinary team, **AND**

- Are medically unstable as manifested by one or more of the following:
  - hypothermia;
  - hypotension;
  - bradycardia or persistent tachycardia;
  - dehydration confirmed on clinical and laboratory grounds;
  - electrolyte abnormalities;
  - congestive heart failure.

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.

### Orthotic Devices and Prosthetic Devices - Artificial Arms, Legs, Feet and Hands

Benefits are provided for orthotic devices or prosthetic devices, including repairs or replacements that are determined by a qualified Physician to be medically appropriate to restore or maintain your ability to perform activities of daily living or essential job related activities and are not solely for comfort or convenience.

For purposes of this benefit "prosthetic device" means an artificial arm or leg (including the hand or foot if it is a portion of a prosthetic arm or leg). Also for purposes of this benefit, "orthotic device" means a medically appropriate custom fabricated brace or support that is designed as a component of an artificial arm or leg.

### Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

### Pharmaceutical Products - Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

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

## Physician Fees for Surgical and Medical Services

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

## Physician's Office Services - Sickness and Injury

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

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

Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office. This also includes CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

**Please Note**
Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

## Podiatry

The Plan pays Benefits for foot expenses including services in connection with weak, strained or flat fleet, any instability or imbalance of the foot, metatargsalgia and plantar fasciitis. Orthopedic inserts, shoes and corrective shoes are also covered.

Any combination of Network Benefits and Non-Network Benefits is limited to $750 per calendar year.

The following foot care expenses will also be covered but are not subject to the podiatry annual limit stated above:

- open cutting operation/surgery; and
- care of corns, bunions, calluses or toenails when necessary because of diabetes or circulatory problems.

## Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

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

- 48 hours for the mother and newborn child following a vaginal delivery; or

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

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

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

Please remember for Non-Network Benefits, you must notify Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If Personal Health Support is not notified, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

**Healthy moms and babies**
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

## 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;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- annual prostate antigen test;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing

one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights,* under *Covered Health Services.*

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;
- Duration of a rental;
- Timing of an acquisition.

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

For questions about your Preventive Care benefits under this Plan call the number on the back of your ID card.

### Prosthetic Devices

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

- artificial feet and hands (unless they are a portion of a prosthetic arm or leg – then refer to *Orthotic Devices and Prosthetic Devices Artificial Arms, Legs, Feet and Hands*);
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

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

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

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

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

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

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

## Reconstructive Procedures

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

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

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

Breast reduction surgery is a Covered Health Service with documentation of the following functional impairments:

- shoulder grooving or excoriation resulting from the brassiere shoulder straps, due to the weight of the breasts; and
- documentation from medical records of medical services related to complaints of the shoulder, neck or back pain attributable to macromastia; and
- determined not to be cosmetic by Personal Health Support.

Breast reduction surgery is NOT a Covered Health Service when performed to improve appearance or for the purpose of improving athletic performance. Breast reduction surgery is covered when a reconstruction has been performed on the other breast (as part of the federal mandate).

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Note: This exclusion does not apply to newborns as coverage is provided for newborns for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes but is not limited to Benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and

oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

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

Please remember that you must notify Personal Health Support five business days before undergoing a Reconstructive Procedure. When you provide notification, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

### Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

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

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services.

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

### *Habilitative Services*

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

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

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

Benefits are limited to:

- 24 visits per calendar year for physical therapy;
- 24 visits per calendar year for occupational therapy;
- 48 visits per calendar year for speech therapy;
- 24 visits per calendar year for Manipulative Treatment;
- 30 visits per calendar year for post-cochlear implant aural therapy;
- 24 visits per calendar year for pulmonary rehabilitation therapy; and
- 36 visits per calendar year for cardiac rehabilitation therapy.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

### Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

Benefits under this section include:

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

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

### Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

Benefits are available only if:

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

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

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

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

***Note:*** The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 180 days per calendar year.

Please remember for Non-Network Benefits, you must:
- notify Personal Health Support for elective admissions: five business days before admission;
- notify Personal Health Support for non-elective admissions (or admissions resulting from an Emergency: as soon as is reasonably possible.

If Personal Health Support is not notified, (or Personal Health Support is not notified for a non-elective admission), Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact Personal Health Support 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

## Substance Use Disorder Services

Substance Use Disorder Services (also known as 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.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

### *Special Substance Use Disorder Programs and Services*

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

## Surgery - Outpatient

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

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

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

## Temporomandibular Joint (TMJ) Services

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

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

Benefits are provided for surgical treatment if:

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

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations. Benefits for surgical services also include *U.S. Food and Drug Administration (FDA)*-approved TMJ implants only when all other treatment has failed.

Any combination of Network Benefits and Non-Network Benefits is limited to $500 per calendar year.

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

Please remember for Non-Network Benefits, you must notify Personal Health Support five business days before temporomandibular joint services are performed during an Inpatient Hospital Stay in a Hospital. If Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

### Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

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

Please remember for Non-Network Benefits, you must notify Personal Health Support five business days before scheduled dialysis services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. If Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

### Transplantation Services

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

- heart;
- heart/lung;

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

Benefits are also available for cornea transplants. You are not required to notify United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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

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

Non-Network Benefits are limited to $30,000 per transplant.

***Note:*** The services described under *Travel and Lodging* are Covered Health Services only in connection with transplant services received at a Designated Facility.

Please remember for Non-Network Benefits, you must notify United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If United Resource Networks or Personal Health Support is not notified, Benefits will be reduced to 50% of Eligible Expenses.

In addition, for Non-Network Benefits you must contact Personal Health Support 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

## Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);

- transplantation services; and
- cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

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

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 60 miles from the Designated Facility (for CRS and transplantation) or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A combined overall maximum Benefit of $10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all cancer treatments and transplant procedures and CHD treatments during the entire period that person is covered under this Plan.

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

## Treatment of Gender Identity Disorder/Dysphoria

The Plan pays Benefits for the treatment of Gender Identity Disorder/Dysphoria as follows:

- **psychotherapy** for gender identity disorders/dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in Section 6, *Additional Coverage Details*;

- **continuous hormone replacement** - hormones of the desired gender injected by a medical provider.

  ***Note***. Coverage may be available for oral and self-injected hormones under the Prescription Drug Products portion of the Plan. See Section 15, *Outpatient Prescription Drugs*, for coverage details and exclusions;

- genital surgery and surgery to change secondary sex characteristics (including thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty).

The Covered Person must meet all of the following eligibility qualifications for hormone replacement:

- age 18 years or older;
- demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks;
- the Covered Person must meet the definition of Gender Identity Disorder:
  - A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)
  - Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex
  - The disturbance is not concurrent with a physical intersex condition
  - The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
  - Initial hormone therapy must be preceded by either:
    - a documented real-life experience of at least three months prior to the administration of hormones; or
    - a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months)

The Covered Person must meet all of the following eligibility qualifications for genital surgery and surgery to change secondary sex characteristics:

- The surgery must be performed by a qualified provider at a facility with a history of treating individuals with gender identity disorder;
- The treatment plan must conform to the most recent edition of the *World Professional Association for Transgender Health (WPATH), Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*;
- For irreversible surgical interventions, the patient must be age 18 years or older;
- Has completed 12 months of continuous hormone therapy for those without contraindications; and
- Prior to surgery, the patient must complete 12 months of successful continuous full time real life experience in the desired gender.

Important:

- Certain patients will be required to complete continuous hormone therapy prior to surgery. In consultation with the patient's physician, this will be determined on a case-by-case basis through the Prior Authorization process.
- Augmentation mammoplasty is allowed if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role; and

■ **laboratory testing** to monitor the safety of continuous hormone therapy.

The Claims Administrator has specific guidelines regarding Benefits for Treatment of Gender Identity Disorder. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Any combination of Network and Non-Network Benefits for treatment of Gender Identity Disorder is limited to $25000 per calendar year and $75,000 during the entire period of time you are enrolled under the Plan. The following services provided under this Benefit apply to this maximum: hormone replacement, related testing and transgender surgery; however, psychotherapy does not apply to this maximum.

For Non-Network Benefits for treatment of Gender Identity Disorder/Dysphoria you must notify the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify the Claims Administrator as required, Benefits will be reduced to 50% of Eligible Expenses.

## Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

## Vision Examinations

The Plan pays Benefits for:

■ vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment); and

■ one routine vision exam, including refraction, to detect vision impairment by a Network provider in the provider's office every other calendar year.

## Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only due to temporary loss of hair resulting from treatment of a malignancy.

Any combination of Network Benefits and Non-Network Benefits is limited to $300 per calendar year.

# SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

**What this section includes:**
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

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

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

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

## Consumer Solutions and Self-Service Tools

### *Health Assessment*

You are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

### *Health Improvement Plan*

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – IACT Medical Trust's way of helping you meet your health and wellness goals.

### *NurseLine℠*

NurseLine is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that IACT Medical Trust has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

*Note:* If you have a medical emergency, call 911 instead of calling NurseLine.

**Your child is running a fever and it's 1:00 AM. What do you do?**
Call NurseLine toll-free any time, 24 hours a day, seven days a week. You can count on NurseLine to help answer your health questions.

With NurseLine, you also have access to nurses online. To use this service, log onto **myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

*Note:* If you have a medical emergency, call 911 instead of logging onto **myuhc.com**.

### *Reminder Programs*

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

- mammograms for women between the ages of 51 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

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

### *Treatment Decision Support*

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

This program offers:

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

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;

- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

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

### *UnitedHealth Premium℠ Program*

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth Premium Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth Premium Program including how to locate a UnitedHealth Premium Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

### *www.myuhc.com*

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

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

- 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;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

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

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

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

Periodically, **www.myuhc.com** hosts live events with leading health care professionals. After viewing a presentation, you can chat online with the experts. Topics include:

- weight control;
- parenting;
- heart disease;
- relationships; and
- depression.

For details, or to participate in a live event, log onto **www.myuhc.com**.

**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.

## Disease and Condition Management Services

### *Disease Management Services*

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, 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 mailed to your home 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; and
- toll-free 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 the back of your ID card.

### *HealtheNotes℠*

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

## Wellness Programs

### *Healthy Back Program*

UnitedHealthcare provides a program that identifies, assesses, and supports members with acute and chronic back conditions. By participating in this program you may receive free educational information through the mail and may even be called by a registered nurse who is a specialist in acute and chronic back conditions. This nurse will be a resource to advise and help you manage your condition.

This program offers:

- education on back-related information and self-care strategies;
- management of depression related to chronic back pain; and
- support in choosing 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 the back of your ID card.

### *Healthy Pregnancy Program*

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

# SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

**What this section includes:**

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

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

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

## Alternative Treatments

1. acupressure
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complimentary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

## Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment

of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

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

   - extractions (excluding impacted wisdom teeth and any associated anesthesia charges);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*.

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 6, *Additional Coverage Details*.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*. This exclusion does not apply to dental care as described under *Anesthesia/Hospital Coverage for Dental Care* as described under Section 6, *Additional Coverage Details*.

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

## Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;

2. orthotic appliances and devices, except when all of the following are met:

   - prescribed by a Physician for a medical purpose; and
   - custom manufactured or custom fitted to an individual Covered Person.

Examples of excluded orthotic appliances and devices include but are not limited to any braces that can be obtained without a Physician's order. This exclusion does not apply to orthotic devices as described under *Orthotic Devices and Prosthetic Devices - Artificial Arms, Legs, Feet and Hands* in Section 6, *Additional Coverage Details*. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

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. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. devices and computers to assist in communication and speech except for speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details* ; and

6. oral appliances for snoring.

## Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over the counter drugs and treatments.

## Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

## Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* or Podiatry Services in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

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

3. shoe lifts and wedges.

## Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - elastic stockings, ace bandages, diabetic strips, and syringes;

This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or
   - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect; and

4. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

## Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - for Autism Spectrum Disorders Services* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance-related and addictive disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
   - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
   - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
   - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
   - not clinically appropriate for the patient's Mental illness, substance-related and addictive disorders or condition based on generally accepted standards of medical practice and benchmarks.
3. Mental Health Services as treatments for R and T -code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge-eating disorders, neurological disorders and other disorders with a known physical basis;
5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;
6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
8. learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
9. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
11. all unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; and

13. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

## Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. inpatient or outpatient pediatric feeding programs are not covered for members who have any of the following:

   - are age 3 and older;
   - are without a history of corrective surgery for a physical defect that caused earlier feeding problems;
   - have a primary diagnosis of failure to thrive;
   - are currently using parenteral nutrition;
   - have developmental, age-related behavioral issues (e.g., temper tantrums) as the primary cause of food refusal; or
   - refuse certain food groups but not others.

3. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). This exclusion does not apply to Medical Foods required as treatment for Inherited Metabolic Disease as described under *Inherited Metabolic Disease Treatment* in Section 6, *Additional Coverage Details*;
   - infant formula available over the counter;
   - donor breast milk;
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements; and

4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

## Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

5. supplies, equipment and similar incidentals for personal comfort. Examples include:

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

## Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

Note: This exclusion does not apply to newborns as coverage is provided for newborns for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage includes but is not limited to Benefits for inpatient or outpatient expenses arising from medical and dental treatment, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate.

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;

4. treatment of benign gynecomastia (abnormal breast enlargement in males).

## Procedures and Treatments

1. biofeedback;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including but not limited to routine, long-term or maintenance/preventive treatment;

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. treatment of tobacco dependency;

10. chelation therapy, except to treat heavy metal poisoning;

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, alignment of the vertebral column, such as asthma or allergies;

12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;

13. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity even if there is a diagnosis of morbid obesity;

14. medical and surgical treatment of hyperhidrosis (excessive sweating);

15. the following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations. Orthognathic surgery (procedure to correct underbite or overbite) jaw alignment and treatment for the temporomandibular joint, except as treatment of obstructive sleep apnea; and

16. breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6 *Additional Coverage Details*.

## Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

## Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment

   This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);
3. surrogate parenting, donor eggs, donor sperm and host uterus;
4. the reversal of voluntary sterilization;
5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
6. services provided by a doula (labor aide); and
7. parenting, pre-natal or birthing classes.

## Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

## Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and

3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

### Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion.

### Treatment of Gender Identity Disorder

1. reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;

2. sperm preservation in advance of hormone treatment or gender surgery;

3. cryopreservation of fertilized embryos;

4. voice modification surgery; and

5. facial feminization surgery, including but not limited to: facial bone reduction, face "lift," facial hair removal, and certain facial plastic procedures.

### Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 14, *Glossary;*

3. multi-disciplinary pain management programs provided on an inpatient basis;

4. Private Duty Nursing;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under *Hospice Care* in Section 6, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants; and

8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

## Vision and Hearing

1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);

2. purchase cost and associated fitting charges for eyeglasses or contact lenses;

3. bone anchored hearing aids except when either of the following applies:

   - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
   - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid;

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

4. eye exercise or vision therapy; and

5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

## All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

3. charges prohibited by federal anti-kickback or self-referral statutes;

4. diagnostic tests that are:

   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

5. expenses for health services and supplies:

   - that do not meet the definition of a Covered Health Service in Section 14, *Glossary*;

- that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
- that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
- for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan; or
- that exceed Eligible Expenses or any specified limitation in this SPD;
- for which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products; and

8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

   - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
   - conducted for purposes of medical research;
   - related to judicial or administrative proceedings or orders; or
   - required to obtain or maintain a license of any type.

# SECTION 9 - CLAIMS PROCEDURES

**What this section includes:**

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

## Network Benefits

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

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

## Non-Network Benefits

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

## Prescription Drug Benefit Claims

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 when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay 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.

## If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting the Human Resources Department. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Participant;

- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
  - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

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

The above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

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

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

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

## Health Statements

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

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

## Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

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

## Claim Denials and Appeals

### *If Your Claim is Denied*

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

### *How to Appeal a Denied Claim*

If you wish to appeal a denied pre-service request for Benefits or post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

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

You or your enrolled Dependent may send a written request for an appeal to:

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

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

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

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

### *Review of an Appeal*

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

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

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

### *Filing a Second Appeal*

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from IACT Medical Trust within 180 days from receipt of the first level appeal determination. You should include a detailed explanation of the claim, the total amount of charges being appealed and your reasoning why the prior denials were not correct. Appeals received by the first of the month prior to the next regularly scheduled Board meeting (for example, March 1 for the April Board meeting) will be heard at that meeting. Appeals received after this date will be heard at the next scheduled Board meeting (appeals received on March 15 could be held over to be heard at the July quarterly Board meeting).

***Note:*** Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. IACT Medical Trust's decision will be final.

## Federal External Review Program

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

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

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

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received IACT Medical Trust's decision.

An external review request should include all of the following:

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

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

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

### *Standard External Review*

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

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

- a decision by the IRO.

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

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

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

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

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

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

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

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

### *Expedited External Review*

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

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

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

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

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

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

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

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

### *Timing of Appeals Determinations*

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

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

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

| **Urgent Care Request for Benefits*** | |
|---|---|
| **Type of Request for Benefits or Appeal** | **Timing** |
| If your request for Benefits is incomplete, UnitedHealthcare must notify you within: | **24 hours** |
| You must then provide completed request for Benefits information to UnitedHealthcare within: | **48 hours** after receiving notice of additional information required |
| UnitedHealthcare must notify you of the benefit determination within: | **72 hours** |
| If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| UnitedHealthcare 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 UnitedHealthcare 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, UnitedHealthcare must notify you within: | **5 days** |
| If your request for Benefits is incomplete, UnitedHealthcare must notify you within: | **15 days** |
| You must then provide completed request for Benefits information to UnitedHealthcare within: | **45 days** |
| UnitedHealthcare 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 |
| UnitedHealthcare 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 |
| IACT Medical Trust must notify you of the second level appeal decision within: | **15 days** after receiving the second level appeal |

| Post-Service Claims | |
|---|---|
| **Type of Claim or Appeal** | **Timing** |
| If your claim is incomplete, UnitedHealthcare must notify you within: | **30 days** |
| You must then provide completed claim information to UnitedHealthcare within: | **45 days** |
| UnitedHealthcare 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** |

| Post-Service Claims | |
|---|---|
| **Type of Claim or Appeal** | **Timing** |
| You must appeal an adverse benefit determination no later than: | **180 days** after receiving the adverse benefit determination |
| UnitedHealthcare 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 |
| IACT Medical Trust must notify you of the second level appeal decision within: | **30 days** after receiving the second level appeal |

### *Concurrent Care Claims*

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

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

## Limitation of Action

You cannot bring any legal action against IACT Medical Trust or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against IACT Medical Trust or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against IACT Medical Trust or the Claims Administrator.

You cannot bring any legal action against IACT Medical Trust or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against IACT Medical Trust or the Claims Administrator you must do so within three years of the date you

are notified of our final decision on your appeal or you lose any rights to bring such an action against IACT Medical Trust or the Claims Administrator.

# SECTION 10 - COORDINATION OF BENEFITS (COB)

**What this section includes:**

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

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

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

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

**Don't forget to update your Dependents' Medical Coverage Information**
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

## Determining Which Plan is Primary

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

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

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

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

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

## When This Plan is Secondary

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

- the Plan determines the amount it would have paid had it been the only plan involved.

- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

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

When this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

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

## When a Covered Person Qualifies for Medicare

### *Determining Which Plan is Primary*

To the extent 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; and
- individuals with end-stage renal disease, for a limited period of time.

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

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

## Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan 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 Plan 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 UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

## Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare 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 Trust may recover the amount in any form as permissible by law. The Trust also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

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

### *Refund of Overpayments*

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

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

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

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

## SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

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

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

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- 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; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
  - providing any relevant information requested by the Plan;
  - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
  - responding to requests for information about any accident or injuries;
  - making court appearances;
  - obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
  - complying with the terms of this section.

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

- The Plan has a first priority right to receive payment on any claim against a 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, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, 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 shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

## Right of Recovery

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

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

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

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

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

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

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

## SECTION 12 - WHEN COVERAGE ENDS

**What this section includes:**

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, IACT Medical Trust will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

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

- the date your employment with the Employer ends;
- the date the Plan ends;
- the date you stop making the required contributions;
- the date you are no longer eligible;
- the date UnitedHealthcare receives written notice from IACT Medical Trust to end your coverage, or the date requested in the notice, if later; or
- the date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date you stop making the required contributions;
- the date UnitedHealthcare receives written notice from IACT Medical Trust to end your coverage, or the date requested in the notice, if later;
- the last day of the year your Dependent child no longer qualifies as a Dependent under this Plan; or
- the date your Dependents no longer qualify as Dependents under this Plan.

### *Other Events Ending Your Coverage*

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to IACT Medical Trust's staff, UnitedHealthcare's staff, a provider or another Covered Person.

*Note*: IACT Medical Trust has the right to demand that you pay back Benefits IACT Medical Trust paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

## Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to IACT Medical Trust proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon IACT Medical Trust's request, that the child continues to meet these conditions.

The proof might include medical examinations at IACT Medical Trust's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

## Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- the Total Disability ends; or
- as permitted by company policy.

## Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if IACT Medical Trust is subject to the provisions of COBRA.

### *Continuation Coverage under Federal Law (COBRA)*

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Participant;
- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

### *Qualifying Events for Continuation Coverage under COBRA*

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

| If Coverage Ends Because of the Following Qualifying Events: | You May Elect COBRA: | | |
|---|---|---|---|
| | For Yourself | For Your Spouse | For Your Child(ren) |
| Your work hours are reduced | 18 months | 18 months | 18 months |
| Your employment terminates for any reason (other than gross misconduct) | 18 months | 18 months | 18 months |
| You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1] | 29 months | 29 months | 29 months |
| You die | N/A | 36 months | 36 months |

| If Coverage Ends Because of the Following Qualifying Events: | You May Elect COBRA: | | |
|---|---|---|---|
| | For Yourself | For Your Spouse | For Your Child(ren) |
| You divorce (or legally separate) | N/A | 36 months | 36 months |
| Your child is no longer an eligible family member (e.g., reaches the maximum age limit) | N/A | N/A | 36 months |
| You become entitled to Medicare | N/A | See table below | See table below |

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

### *How Your Medicare Eligibility Affects Dependent COBRA Coverage*

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

| If Dependent Coverage Ends When: | You May Elect COBRA Dependent Coverage For Up To: |
|---|---|
| You become entitled to Medicare and don't experience any additional qualifying events | 18 months |
| You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires | 36 months |
| You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan | 36 months |

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

### *Getting Started*

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2*, Introduction*.

### *Notification Requirements*

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

### *Notification Requirements for Disability Determination*

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Human Resources Department with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

### *Trade Act of 2002*

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

## When COBRA Ends

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium (premium is not paid within 30 days of its due date);
- the date the entire Plan ends; or

- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

*Note*: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

## Early Retiree Benefits Under Indiana Law

If you retire prior to age 65 and satisfy certain requirements under Indiana law, you will be offered the choice between two medical coverage continuation options: (a) COBRA coverage under federal law; and (b) early retiree coverage under Indiana law. The chart below provides a basic comparison of the two options that will apply in most situations.

| **Option A: COBRA Coverage** | **-OR-** | **Option B: Early Retiree Coverage** |
|---|---|---|
| Eligibility: Employees eligible upon termination of employment (unless for cause). | | Eligibility: Employees eligible for coverage include:<br><br>1. Retired Public Safety Employees as defined in I.C. 5-10-8-2.2 (b),<br>2. Retired Employees as defined in I.C. 5-10-8-1(8)(A), who will have:<br>(i) Reached fifty-five (55) years of age on or before the employee's retirement date but will not be eligible on that date for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*;<br><br>(ii) Completed twenty (20) years of creditable employment with a public employer on or before the employee's retirement date, ten (10) years of which must have been completed immediately preceding the retirement date; and<br><br>(iii) Completed at least fifteen (15) years of participation in the retirement plan of which the employee is a member on or before the employee's |

| | | |
|---|---|---|
| | | retirement date. |
| Cost to Employee: 102% of cost of coverage. | | Cost to Employee: 100% of the cost of coverage. |
| Duration: Up to 18 months; coverage terminates with other group or Medicare enrollment. | | Duration: Coverage terminates upon Medicare eligibility. |
| Spousal and Dependent Coverage: Yes | | Spousal and Dependent Coverage: Yes |

In many cases, early retiree coverage under Indiana law offers greater benefits than COBRA coverage. However, each situation is unique and you are ultimately responsible to determine which option is better for you.

### *Enrolling in Early Retiree Coverage*

If you decide to elect early retiree coverage under Indiana law, you will need to take the following steps:

- be enrolled in the IACT Medical Trust at the date of your retirement; **or**
- provide written notice and enroll in the IACT Medical Trust on or before the 90th day following your retirement date.

Your Spouse and Dependents must also either be enrolled in the IACT Medical Trust at the time of your retirement, or, alternatively, must enroll on or before the 90th day following your retirement date to be eligible for early retiree coverage. If not enrolled during this period, the Spouse and/or Dependents may only enroll in the IACT Medical Trust during a special enrollment. Special enrollment rights for early retirees are limited to marriage, birth, adoption or placement for adoption.

### *Termination*

If you are an early retiree, your eligibility to participate in the IACT Medical Trust will terminate upon the date you become eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq*. If you are an early retiree and decide to terminate your coverage prior to Medicare eligibility, coverage for your Spouse and Dependents will also terminate at that time.

If you are an early retiree and you die prior to Medicare eligibility, your Spouse will be eligible to participate in the Trust until the earliest of: (a) the date that s/he becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq*.; (b) the date s/he remarries; or (c) the date the Spouse becomes eligible for another employer-sponsored medical plan.

If you are an early retiree and your coverage terminates upon Medicare eligibility, your Spouse will be eligible to participate in the Trust until the earliest of: (a) the date that s/he becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq*.; or (b) if you die, the date that s/he remarries.

Coverage for other Dependents will terminate upon the earliest of: (a) the date the Dependent no longer satisfies the definition of "Dependent" established by the Trust; (b) the date your coverage terminates as an early retiree; or (c) the date the Dependent becomes eligible for another employer-sponsored medical plan or Medicare. If a Dependent cannot work to support him/herself due to mental retardation or physical or mental handicap, coverage for the Dependent will terminate when neither the Early Retiree nor the Spouse is covered by the Trust. Verification of Dependent status may be required at any time.

Notwithstanding the foregoing, coverage for you, your Spouse and any Dependents will terminate immediately if you fail to pay your premiums in a timely manner. In addition, if your town withdraws from the Trust, or withdraws the class of employees from the Trust to which you were included when employed, coverage for you, your Spouse and any Dependents will terminate.

### *Benefits for Public Safety Employees Receiving Disability Benefits*

If you are a public safety employee who is receiving disability benefits under the 1925 Police Pension Fund, the 1937 Firefighters' Pension Fund, the 1953 Police Pension Fund, the 1977 Police Officers' and Firefighters' Pension and Disability Fund or a sheriff's disability fund established pursuant to Indiana Code § 36-8-10, you may be eligible for continuing medical coverage as described in this section.

To elect continuing medical coverage, you will need to take the following steps:

- be enrolled in the IACT Medical Trust at the date of your disability; **or**
- provide written notice and enroll in the IACT Medical Trust within 90 days following the date you begin receiving disability benefits.

Your Spouse and Dependents must also either be enrolled in the IACT Medical Trust at the time of your disability, or, alternatively, must enroll within 90 days following the date you begin receiving disability benefits. If not enrolled during this period, the Spouse and/or Dependents may only enroll in the IACT Medical Trust during a special enrollment.

### *Termination*

If you are a disabled public safety employee, your eligibility to participate in the IACT Medical Trust will terminate upon the date you become eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq*. If you are a disabled public safety employee and decide to terminate your coverage prior to Medicare eligibility, coverage for your Spouse and Dependents will also terminate at that time.

If you are a disabled public safety employee and you die prior to Medicare eligibility, your Spouse will be eligible to participate in the Trust until the earliest of: (a) the date that s/he becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*; (b) the date s/he remarries; or (c) the date the Spouse becomes eligible for another employer-sponsored medical plan.

If you are a disabled public safety employee and your coverage terminates upon Medicare eligibility, your Spouse will be eligible to participate in the Trust until the earliest of: (a) the

date that s/he becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*; or (b) if you die, the date that s/he remarries.

Coverage for other Dependents will terminate upon the earliest of: (a) the date the Dependent no longer satisfies the definition of "Dependent" established by the Trust; (b) the date your coverage terminates as a disabled public safety employee; or (c) the date the Dependent becomes eligible for another employer-sponsored medical plan or Medicare. If a Dependent cannot work to support him/herself due to mental retardation or physical or mental handicap, coverage for the Dependent will terminate when neither the disabled public safety employee nor the Spouse is covered by the Trust. Verification of Dependent status may be required at any time.

Notwithstanding the foregoing, coverage for you, your Spouse and any Dependents will terminate immediately if you fail to pay your premiums in a timely manner. In addition, if your town withdraws from the Trust, or withdraws the class of employees from the Trust to which you were included when employed, coverage for you, your Spouse and any Dependents will terminate.

### *Benefits for Surviving Spouses and Dependents of Public Safety Employees Who Die While in Active Service*

Except as provided by Indiana law, a Surviving Spouse or Dependent of a public safety employee who dies in the line of duty shall be entitled to continuing medical coverage.

To elect continuing medical coverage, you will need to take the following steps:

- be enrolled in the IACT Medical Trust as of the date of death of the public safety employee; **or**
- provide written notice and enroll in the IACT Medical Trust within 90 days following the date of death of the public safety employee.

### *Termination*

If you are the Surviving Spouse of a public safety employee who dies in the line of duty, you will be eligible to participate in the Trust until the earliest of: (a) the date that you becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 *et seq.*; (b) the date you remarry; or (c) the date you becomes eligible for another employer-sponsored medical plan.

If you are the Dependent of a public safety employee who dies in the line of duty, you will be eligible to participate in the Trust until the earliest of: (a) the date you no longer satisfies the definition of "Dependent" established by the Trust; or (b) the date you becomes eligible for another employer-sponsored medical plan or Medicare. Verification of Dependent status may be required at any time.

Notwithstanding the foregoing, coverage for the Surviving Spouse or Dependent of a public safety employee who dies in the line of duty will terminate immediately if premiums are not paid in a timely manner. In addition, if the town withdraws from the Trust, or withdraws

public safety employees from the Trust, coverage for the Surviving Spouse and Dependents will terminate.

## Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Participant's absence from work; or
- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

# SECTION 13 - OTHER IMPORTANT INFORMATION

**What this section includes:**

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and IACT Medical Trust;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

## Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

***Note:*** A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

## Your Relationship with UnitedHealthcare and IACT Medical Trust

In order to make choices about your health care coverage and treatment, IACT Medical Trust believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit Plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- IACT Medical Trust and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare 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 Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

IACT Medical Trust and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. IACT Medical Trust and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. IACT Medical Trust and UnitedHealthcare will use de-identified data for commercial purposes including research.

## Relationship with Providers

The relationships between IACT Medical Trust, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not IACT Medical Trust's agents or employees, nor are they agents or employees of UnitedHealthcare. IACT Medical Trust and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

IACT Medical Trust and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, IACT Medical Trust and UnitedHealthcare arranges for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not IACT Medical Trust's employees nor are they employees of UnitedHealthcare. IACT Medical Trust and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. IACT Medical Trust and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

IACT Medical Trust and the Plan Administrator are solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

## Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

## Interpretation of Benefits

IACT Medical Trust and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

IACT Medical Trust and UnitedHealthcare may delegate 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, IACT Medical Trust may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that IACT Medical Trust does so in any particular case shall not in any way be deemed to require IACT Medical Trust to do so in other similar cases.

## Information and Records

IACT Medical Trust and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. IACT Medical Trust and UnitedHealthcare may request additional information from you to decide your claim for Benefits. IACT Medical Trust and UnitedHealthcare will keep this information confidential. IACT Medical Trust and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish IACT Medical Trust and UnitedHealthcare with all information or copies of records relating to the services provided to you. IACT Medical Trust and UnitedHealthcare have 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. IACT Medical Trust and UnitedHealthcare agree that such information and records will be considered confidential.

IACT Medical Trust and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms

of the Plan, for appropriate medical review or quality assessment, or as IACT Medical Trust is required to do by law or regulation. During and after the term of the Plan, IACT Medical Trust and UnitedHealthcare and its 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.

For complete listings of your medical records or billing statements IACT Medical Trust recommends that you 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 UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, IACT Medical Trust and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as does the Plan Administrator.

## Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare 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; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health 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.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

## Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but IACT Medical Trust recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

## Rebates and Other Payments

IACT Medical Trust and UnitedHealthcare may receive rebates for certain drugs that are administered to you 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 your Annual Deductible. IACT Medical Trust and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

## Workers' Compensation Not Affected

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

## Future of the Plan

Although the Trust 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 Trust'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 Trust 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 Trust 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 Trust and others as may be required by any applicable law.

## Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. 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 this document by written request to the Plan Administrator, for a nominal charge.

# SECTION 14 - GLOSSARY

**What this section includes:**
- Definitions of terms used throughout this SPD.

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

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

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

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

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

**Annual Deductible (or Deductible)** – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

**Autism Spectrum Disorders** – a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities including but not limited to Asperger's syndrome Autism, Rhett's Syndrome, Childhood Disintegrated Disorder and Pervasive Development Disorders Not Otherwise Specified (PDDNOS) as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.*

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

**Cancer Resource Services (CRS)** – a program administered by UnitedHealthcare or its affiliates made available to you by IACT Medical Trust. The CRS program provides:

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

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

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

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

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

**Coinsurance** – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

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

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

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

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

**Copayment (or Copay)** – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

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

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

**Covered Health Services** – those health services, including services, supplies or Pharmaceutical Products, which IACT Medical Trust determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- consistent with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines as described below;
- not provided for the convenience of the Covered Person, Physician, facility or any other person;
- included in Sections 5 and 6, Plan Highlights and Additional Coverage Details;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

In applying the above definition, "scientific evidence" and "prevailing medical standards" have the following meanings:

- "scientific evidence" means the results of controlled Clinical Trials or other studies published in peer-reviewed, medical literature generally recognized by the relevant medical specialty community; and
- "prevailing medical standards and clinical guidelines" means nationally recognized professional standards of care including, but not limited to, national consensus statements, nationally recognized clinical guidelines, and national specialty society guidelines.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

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

**CRS** – see Cancer Resource Services (CRS).

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

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);

- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

**Deductible** – see Annual Deductible.

**Dependent** – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

**Designated Facility** – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specific conditions.

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

**Domiciliary Care** – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

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

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

**Eligible Expenses** – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and

validation of all provider billings in accordance with one or more of the following methodologies:

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

**Emergency** – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or Substance Use Disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

**Emergency Health Services** – health care services and supplies necessary for the treatment of an Emergency.

**Employer** – City of Greenfield.

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

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

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

Exceptions:

- Clinical trials for which Benefits are available as described under Clinical Trials in Section 6, *Additional Coverage Details*.

- If you are not a participant in a qualifying Clinical Trial as described under Section 6, Additional Coverage Details, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and IACT Medical Trust may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and IACT Medical Trust must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

**Full-time Student** – a person who is enrolled in and attending, full-time, a recognized course of study or training at:

- an accredited high school;
- an accredited college or university; or
- a licensed vocational, technical, automotive, or beautician school, or similar training school.

The educational institution determines what constitutes Full-time Student status. You are no longer a Full-time Student as of the end of the calendar year during which you graduate or otherwise cease to be enrolled and in attendance at the institution on a full-time basis.

You continue to be a Full-time Student during periods of regular vacation established by the institution. If you do not continue as a Full-time Student immediately following the period of vacation, the Full-time Student designation will end as described above.

**Gender Identity Disorder** – A disorder characterized by the following diagnostic criteria:

- a strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex);
- persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex;
- the disturbance is not concurrent with a physical intersex condition;

- the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning;
- the transsexual identity has been present persistently for at least two years; and
- the disorder is not a symptom of another mental disorder or a chromosomal abnormality.

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

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

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

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

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

**Inherited Metabolic Disease** – a disease that is caused by inborn errors of amino acid, organic acid or urea cycle metabolism and is treatable by the dietary restriction of one or more amino acids.

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

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

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

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

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

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

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

**Kidney Resource Services (KRS)** – a program administered by UnitedHealthcare or its affiliates made available to you by IACT Medical Trust. The KRS program provides:

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

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

**Medical Foods** – a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.

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

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

**Mental Health Services** – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

**Mental Health/Substance Use Disorder (MH/SUD) Administrator** – the organization or individual designated by IACT Medical Trust who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

**Mental Illness** – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

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

common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

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

**Network Benefits** - description of how Benefits are paid for Covered Health Services provided by Network provider. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

**Non-Network Benefits** - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

**Open Enrollment** – the period of time, determined by IACT Medical Trust, during which eligible Participants may enroll themselves and their Dependents under the Plan. IACT Medical Trust determines the period of time that is the Open Enrollment period.

**Out-of-Pocket Maximum** – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

**Partial Hospitalization/Day Treatment** – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

**Participant** – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

**Personal Health Support** – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

**Personal Health Support Nurse** – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

**Pharmaceutical Products** – FDA-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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

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

**Plan** – The IACT Medical Trust Medical Plan.

**Plan Administrator** – IACT Medical Trust or its designee.

**Plan Sponsor** – IACT Medical Trust.

**Pregnancy** – includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

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

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

**Reconstructive Procedure** – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

**Residential Treatment Facility** – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;

- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

**Retired Employee** – an Employee who retires while covered under the Plan.

**Semi-private Room** - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

**Shared Savings Program** - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

**Sickness** – physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

**Skilled Care** – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including, but not limited to, dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and

- they are not Custodial Care, as defined in this section.

**Skilled Nursing Facility** – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

**Spouse** – an individual to whom you are legally married.

**Substance Use Disorder Services** - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded.

**Total Disability** – a Participant's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

**Transitional Care** – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

**UnitedHealth Premium Program** – a program that identifies network Physicians or facilities that have been designated as a UnitedHealth Premium Program Physician or facility for certain medical conditions.

To be designated as a UnitedHealth Premium provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium Program Physician or facility.

**Unproven Services** – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and IACT Medical Trust may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and IACT Medical Trust must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and IACT Medical Trust's discretion. Other apparently similar promising but unproven services may not qualify.

**Urgent Care** – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

**Urgent Care Center** – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

# SECTION 15 - PRESCRIPTION DRUGS

**What this section includes:**

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

## Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

You are responsible for paying any amounts due to the pharmacy at the time you receive your prescription drugs. If you purchase a Prescription Drug from a non-Network Pharmacy, you are responsible for any difference between what the non-Network Pharmacy charges and the amount the Plan would have paid for the same Prescription Drug dispensed by a Network Pharmacy.

| **Covered Health Services**[1,2, 3] | **Percentage of Prescription Drug Cost Payable by the Plan:** | **Percentage of Predominant Reimbursement Rate Payable by the Plan:** |
|---|---|---|
| | **Network** | **Non-Network** |
| **Retail** - up to a 31-day supply or 90 day supply at 3 Copays | 100% after you pay a: | |
| ■ Generic | $15 Copay | $15 Copay |
| ■ Preferred Brand-name Drug | $30 Copay | $30 Copay |
| ■ Non-preferred Brand-name Drug | $50 Copay | $50 Copay |
| **Mail Order** - up to a 90-day supply | 100% after you pay a: | |
| ■ Generic | $30 Copay | Not Covered |
| ■ Preferred Brand-name Drug | $60 Copay | Not Covered |
| ■ Non-preferred Brand-name Drug | $100 Copay | Not Covered |

| Covered Health Services[1,2, 3] | Percentage of Prescription Drug Cost Payable by the Plan: | Percentage of Predominant Reimbursement Rate Payable by the Plan: |
|---|---|---|
| | Network | Non-Network |

[1]You must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

[2]You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

[3]Diabetic supplies and medications under the pharmacy benefit will be covered at 100% - no member responsibility for paying a Copayment and/or Coinsurance.

***Note***: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drugs as described in this section. Benefits for Prescription Drugs will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

## Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug 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 will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

## Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

The Plan pays Benefits at different levels for Generic, Preferred Brand-name, and Non-preferred Brand-name Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three categories on the Preferred Drug List (PDL). The category status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic category decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its category assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each category is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the categories work:

- Generic is your lowest Copay option. For the lowest out-of-pocket expense, you should consider Generic Drugs if you and your Physician decide they are appropriate for your treatment.
- Preferred Brand-name Drugs are your middle Copay option. Preferred Brand-name Drugs are Brand-name Drugs that are on the Preferred Drug List. Consider a Preferred Brand-name Drug if no Generic Drug is available to treat your condition.
- Non-preferred Brand-name Drugs are your highest Copay option. Non-preferred Brand-name Drugs are Brand-name Drugs that are not on the Preferred Drug List. Preferred Brand-name drugs are usually more costly. Sometimes there are Generic and Preferred Brand-name alternatives.

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

- the applicable Copay;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Cost that UnitedHealthcare agreed to pay the Network Pharmacy.

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

- the applicable Copay; or
- the Prescription Drug cost for that particular Prescription Drug.

## Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay. If you purchase a Prescription Drug from a non-Network Pharmacy, you are responsible for any difference between what the non-Network Pharmacy charges and the amount the Plan would have paid for the same Prescription Drug dispensed by a Network Pharmacy.

The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day supply or a 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day or 90-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied.

***Note:*** Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

## Mail Order

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

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

***Note:*** To maximize your benefit, ask your Physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any prescription order or refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

## Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drugs*. You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

## Designated Pharmacy

If you require Specialty Prescription Drugs, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Specialty Prescription Drugs.

You may fill a prescription for Specialty Prescription Drugs up to two times at a Pharmacy. However, after that you will be directed to a Designated Pharmacy and if you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid and you will be responsible for paying all charges.

Please see the *Prescription Drug Glossary* in this section for definitions of Specialty Prescription Drug and Designated Pharmacy.

**Want to lower your out-of-pocket Prescription Drug costs?**
Consider Generic Prescription Drugs, if you and your Physician decide they are appropriate.

## Assigning Prescription Drugs to the PDL

UnitedHealthcare's Preferred Drug List (PDL) Management Committee makes the final approval of Prescription Drug placement in categories. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether supply limits or notification requirements should apply.

Economic factors may include:

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

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

The PDL Management Committee may periodically change the placement of a Prescription Drug among the categories. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Prescription Drug, Preferred Drug List (PDL), and Preferred Drug List (PDL) Management Committee are defined at the end of this section.

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

## Notification Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug is:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

### *Network Pharmacy Notification*

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying the Claims Administrator.

### *Non-Network Pharmacy Notification*

When Prescription Drugs are dispensed at a non-Network Pharmacy, you or your Physician are responsible for notifying the Claims Administrator.

If UnitedHealthcare is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Cost) will not be available to you at a non-Network Pharmacy. If UnitedHealthcare is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not notify the Claims Administrator before the Prescription Drug was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drugs from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drugs from a non-Network Pharmacy), less the required Copayment that applies.

To determine if a Prescription Drug requires notification, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

## Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

### Limitation on Selection of Pharmacies

If the Claims Administrator determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator will select a single Network Pharmacy for you.

### Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a supply limit is subject to UnitedHealthcare's periodic review and modification.

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

### If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the category placement of the Brand-name Drug may change. As a result, your Copay may change. You will pay the Copay applicable for the category to which the Prescription Drug is assigned.

### Special Programs

IACT Medical Trust and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication regimens. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

### Maintenance Medication Program

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications.

### Rebates and Other Discounts

UnitedHealthcare may, at times, receive rebates for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays.

The Claims Administrator and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting,

educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. The Claims Administrator is not required to pass on to you, and does not pass on to you, such amounts.

## Coupons, Incentives and Other Communications

UnitedHealthcare may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition.

UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

## Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed under Section 8, *Exclusions* also apply to this section, except that any preexisting condition exclusion in Section 8, *Exclusions* is not applicable to this section. In addition, the following exclusions apply.

Medications that are:

1. 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;

2. any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

4. 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 over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Claims Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision.

5. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3;

6. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);

7. for smoking cessation in excess of six Prescription Drug fills per calendar year;

8. growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition);

9. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;

10. new drugs and/or new dosages, until they are reviewed and assigned to a category by the PDL Management Committee;

11. prescribed, dispensed or intended for use during an Inpatient Stay;

12. prescribed for appetite suppression, and other weight loss products;

13. prescribed to treat infertility;

14. Prescription Drugs, including new Prescription Drugs or new dosage forms, that IACT Medical Trust determines do not meet the definition of a Covered Health Service;

15. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;

16. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug;

17. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

18. unit dose packaging of Prescription Drugs;

19. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and IACT Medical Trust have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;

20. used for cosmetic purposes;

21. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed; and

22. vitamins, except for the following which require a prescription:

    - prenatal vitamins;
    - vitamins with fluoride; and
    - single entity vitamins.

## Glossary - Prescription Drugs

**Brand-name** - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, First DataBank, that classify drugs as either Brand-name or Generic based on a number of factors.

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

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

**Generic** - a Prescription Drug that is either:

- chemically equivalent to a Brand-name; or
- identified by UnitedHealthcare as a Generic based on available data resources including, but not limited to, First DataBank, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

**Maintenance Medication –** a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

**Network Pharmacy** - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Claims Administrator as a Network Pharmacy.

**Non-preferred Brand-name Drug** - a Brand-name Drug that is not identified by the Claims Administrator as being on the Preferred Drug List (PDL).

**PDL** - see Preferred Drug List (PDL).

**PDL Management Committee** - see Preferred Drug List (PDL) Management Committee.

**Predominant Reimbursement Rate** – the amount the Plan will pay to reimburse you for a Prescription Drug that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. The Claims Administrator calculates the Predominant Reimbursement Rate using its Prescription Drug Cost that applies for that particular Prescription Drug at most Network Pharmacies.

**Preferred Brand-name Drug** - a Brand-name Drug that is identified by the Claims Administrator as being on the Preferred Drug List (PDL).

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

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
  - insulin syringes with needles;
  - blood testing strips - glucose;
  - urine testing strips - glucose;
  - ketone testing strips and tablets;
  - lancets and lancet devices;
  - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
  - glucose monitors.

**Prescription Drug Cost** – the rate the Claims Administrator has agreed to pay its Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

**Preferred Drug List (PDL)** - a list that categorizes into categories medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which category a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

**Preferred Drug List (PDL) Management Committee** - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific categories.

**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 Prescription Drug Deductible or Specialty Prescription Drug 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; or
- 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 determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

**Specialty Prescription Drug** - Prescription Drug that is generally high cost, self-injectable biotechnology drug used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drugs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

**Therapeutically Equivalent** – when Prescription Drugs can be expected to produce essentially the same therapeutic outcome and toxicity.

**Usual and Customary Charge** – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

# SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION

**What this section includes:**
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

### *Additional Plan Description*

**Claims Administrator**: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United HealthCare Services, Inc.
Attn: Claims
185 Asylum Street
Hartford, CT 06103-3408

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

**Type of Administration of the Plan**: 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 Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Services, Inc.. The named fiduciary of Plan is IACT Medical Trust, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

# ATTACHMENT I – HEALTH CARE REFORM NOTICES

## Patient Protection and Affordable Care Act ("PPACA")

### *Patient Protection Notices*

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

# ATTACHMENT II – LEGAL NOTICES

## Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

## Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

# ADDENDUM - UNITEDHEALTH ALLIES

## Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> ***Important***:
> UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

## What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

## Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

> ***Important***:
> You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

## Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

## Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

# ADDENDUM - PARENTSTEPS®

## Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

> ***Important***:
> ParentSteps is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps will collect the provider payment from you online via the ParentSteps website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description 5, *Plan Highlights*) when a benefit is available.

## What is ParentSteps?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

## Registering for ParentSteps

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at www.urnparentsteps.com or by calling ParentSteps toll-free at 1-877-801-3507.

## Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see the specific rates negotiated by ParentSteps with each provider for select types of infertility treatment in order to make an informed decision.

## Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps member. ParentSteps will validate your choice and send a validation email to you and the clinic.

## Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps discounts apply, the provider will enter in your proposed course of treatment. ParentSteps will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps will notify your provider with a statement saying that treatments may begin.

## Speaking with a Nurse

Once you have successfully registered for the ParentSteps program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

## Additional ParentSteps Information

Additional information on the ParentSteps program can be obtained online at www.urnparentsteps.com or by calling 1-877-801-3507 (toll-free).