UnitedHealthcare®

Your plan documents have arrived!

Attached are a Summary of Benefits and Coverage (SBC), Privacy Notice and a Federal Women's Health and Cancer notice.

We are pleased to inform you that your Summary Plan Description (SPD) is now available on the www.myallsaversconnect.com website.

The Summary Plan Description (SPD) can be found by following the steps below:

- Navigate to www.myallsaversconnect.com
- Sign in or select "New user? Register here."
- Select the Benefits & coverage tab along the left side of the screen.
- Scroll to the Benefit Plan Document section of the screen.
- Select the appropriate plan document in the Benefit Plan Document section.

  Note: The document will begin with "ALSV-SELF-FUNDED-MED-MM/DD/YYYY"
  If there are multiple documents, select the document with the most current date.

For assistance in accessing your Summary Plan Description please contact Customer Service Representatives using the number on the back of your ID card.

We appreciate the opportunity to serve you.

SUMMARY PLAN DESCRIPTION

LAKE SAINT LOUIS COMMUNITY

5400-011193

PPO P30003060ELX

Summary Plan Description
LAKE SAINT LOUIS COMMUNITY Medical Plan

SECTION 1 - WELCOME

What this section includes:

- Can this Plan Change?
- How do you use this SPD?

LAKE SAINT LOUIS COMMUNITY is pleased to provide you with this Summary Plan Description (SPD) which describes the health Benefits available to you and your covered family members under the LAKE SAINT LOUIS COMMUNITY Welfare Benefit Plan. It includes summaries of:

- Who is eligible;
- Services that are covered, called Covered Health Care Services;
- Services that are not covered, called Exclusions;
- How Benefits are paid; and
- Your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT
The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 15, Glossary.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not meant that the procedure or treatment is a Covered Health Service under the Plan.

Can this Plan Change?

LAKE SAINT LOUIS COMMUNITY intends to continue this Plan, but reserves the right, as they determine, 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.

United HealthCare Services, Inc. is a private healthcare claims administrator whose goal is to give you the tools you need to make wise healthcare decisions. United HealthCare Services, Inc. also helps your employer to administer claims. Although United HealthCare Services, Inc. will assist you in many ways, it does not guarantee any Benefits. LAKE SAINT LOUIS COMMUNITY is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the LAKE SAINT LOUIS COMMUNITY Welfare Benefit Plan works. If you have questions, contact your Employer or call the number on the back of your ID card.

How Do You Use This SPD?

- Read the entire SPD, and share it with your family.
- 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 may access the most current version of your SPD and any future amendments at www.myallsaversconnect.com.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 15, Glossary.

- LAKE SAINT LOUIS COMMUNITY is also referred to as Company.
- Capitalized words in the SPD have special meanings and are defined in Section 15, Glossary.
- 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.
- 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 employee who is scheduled to work at least 30 hours per week.

Your eligible Dependents, as defined in Section 15, *Glossary,* may also participate in the Plan. An eligible Dependent is considered to be:

- Your Spouse, as defined in Section 15, *Glossary*.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you. A child is no longer eligible as a Dependent when the child reaches age 26 except as provided in Section 11: *Coverage for a Disabled Dependent Child*.

***Note*:** Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the LAKE SAINT LOUIS COMMUNITY Welfare Benefit Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the LAKE SAINT LOUIS COMMUNITY Welfare Benefit Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order (QMCSO)* or other court or administrative order, as described in Section 12: *Other Important Information.*

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Claims 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 Claims Administrator.

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

Cost of Coverage

You and LAKE SAINT LOUIS COMMUNITY 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.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of LAKE SAINT LOUIS COMMUNITY's cost in covering a Domestic Partner may be imputed to the Employee as income. In addition, the share of the Employee's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and LAKE SAINT LOUIS COMMUNITY reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by contacting your Employer.

How to Enroll

To enroll, call your Employer 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 September 01.

Important: If you wish to make allowed coverage changes following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact your Employer 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 your Employer receives your properly completed enrollment, coverage will begin based on the waiting period defined by LAKE SAINT LOUIS COMMUNITY. 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 on the date of your marriage, provided you notify your Employer 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 your Employer within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Care Services related to that Inpatient Stay as long as you receive Covered Health Care Services in accordance with the terms of the Plan.

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

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, legal adoption, placement for adoption or legal guardianship of a child.
- Registering a Domestic Partner.
- 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 qualifies 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 plan sponsor within 60 days of termination).

- You or your Dependent become eligible for a premium assistance subsidy under *Medicaid* or *CHIP* (you must contact plan sponsor within 60 days of determination of subsidy eligibility).

- You or your Dependent lose eligibility for coverage in the individual market, including coverage purchased through a public exchange or other public market established under the Affordable Care Act (Marketplace) (other than loss of eligibility for coverage due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact) regardless of whether you or your Dependent may enroll in other individual market coverage, through or outside of a Marketplace.

- A strike or lockout involving you or your Spouse.

- A court or administrative order.

- Your eligible dependent moves to the United States. This is first time enrollment only. Re-entry to the United States after an extended leave outside of the United States is not a qualifying event for enrollment.

Unless otherwise noted above, if you wish to change your elections, you must contact your Employer who must notify the Claims Administrator, 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 available and 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 LAKE SAINT LOUIS COMMUNITY'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 LAKE SAINT LOUIS COMMUNITY's medical plan outside of annual Open Enrollment.

Late Enrollees for Medical Insurance

If the Claims Administrator receives your enrollment form after the applicable Initial Enrollment Period or a special enrollment period, you are a Late Enrollee (Refer to Section 15, Glossary). If you are a Late Enrollee, your enrollment may be postponed until the next Enrollment Period or a special enrollment period as described above.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Out-of-Network Benefits;
- Network Providers;
- Allowed Amounts;
- Annual Deductible;
- Copayment;
- Coinsurance;
- Out-of-Pocket Limit and
- Review and determine Benefits in accordance with the Claims Administrator's reimbursement policies.

Network and Out-of-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 Care 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 Care Services from Physicians and other health care professionals who have contracted with the Claims Administrator or its affiliates to provide those services.

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

If you receive care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Allowed Amount. The amount in excess of the Allowed Amount could be significant, and this amount does not apply to the Out-of-Pocket Limit. You may want to ask the Out-of-Network provider about their billed charges before you receive care.

Network Providers

The Claims Administrator or its affiliates arrange for health care providers to participate in the Network. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call The Claims Administrator at the toll-free number on your ID card or log onto www.myallsaversconnect.com.

Network providers are independent practitioners and are not employees of LAKE SAINT LOUIS COMMUNITY or the Claims Administrator.

Allowed Amounts

Allowed Amounts are charges for Covered Health Care Services that are provided while the Plan is in effect, determined according to the definition in Section 15, Glossary. For certain Covered Health Care Services, the Plan will not pay these expenses until you have met your Annual Deductible. LAKE SAINT LOUIS COMMUNITY has delegated to Claims Administrator the initial authority to decide whether a treatment or supply is a Covered Health Service and how the Allowed Amounts will be determined and otherwise covered under the Plan.

Don't Forget Your ID Card

Remember to show your 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 Allowed Amount you must pay each Calendar Year for Covered Health Care Services before you are eligible to begin receiving Benefits. There are separate Network and Out-of-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the Calendar Year.

Copayment

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

Coinsurance

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

Out-of-Pocket Limit

The annual Out-of-Pocket Limit is the most you pay each calendar year for Covered Health Care Services. There are separate Network and Out-of-Network Out-of-Pocket Limits for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual limit, the Plan pays 100% of Allowed Amounts for Covered Health Care Services through the end of the calendar year.

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

Plan Features	**Applies to the Network Out-of-Pocket Limit?**	**Applies to the Out-of-Network Out-of-Pocket Limit?**
Copays	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Care Services	No	No
Charges that exceed Allowed Amounts	No	No

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

The Claim Administrator develops its reimbursement policy guidelines, as it determines, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the reimbursement policies are applied to provider billings. The Claims Administrator shares the reimbursement policies with Physicians and other providers in the Network through the provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, Out-of-Network providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the reimbursement policies does not reimburse (in whole or in part) for the service billed.

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

SECTION 4 - SCHEDULE OF BENEFITS

What this section includes:

- How Do You Access benefits?
- Prior Authorization requirements;
- Benefits;
- Annual deductible;
- Deductible carryover from prior carrier
- Out-of-pocket limit;
- Covered Health Care Services and;
- Provider network.

How Do You Access Benefits?

You can choose to receive Network Benefits or Out-of-Network Benefits.

Network Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider.

Emergency Health Care Services are always paid as Network Benefits. Emergency Health Care Services provided by an out-of-Network provider will be reimbursed as set forth under Allowed Amounts as described in the Summary Plan Description. **As a result, you will responsible for the difference between the amount billed by the out-of-Network provider and the amount the Claims Administrator determines to be the Allowed Amount for reimbursement. The payments you make to out-of-Network providers for charges above the Allowed Amount do not apply towards any applicable Out-of-Pocket limit**.

For facility charges, these are Benefits for Covered Health Care Services that are billed by a Network facility and provided under the direction of either a Network or out-of-Network Physician or other provider. Benefits for non-Emergency Health Care Services include Physician services provided in a Network facility by a Network or an out-of-Network Emergency Room Physician, radiologist, anesthesiologist, assistant surgeon, hospitalist, or pathologist.

Covered Health Care Services that are provided at a Network facility by an out-of-Network facility based Physician, when not Emergency Health Care Services, will be reimbursed as set forth under Allowed Amounts as described in the Summary Plan Description. **As a result, you will be responsible for the difference between the amount billed by the out-of-Network facility based Physician and the amount the Claims Administrator determines to be the Allowed Amount for reimbursement. The payments you make to out-of-Network facility based Physicians for charges above the Allowed Amount do not apply towards any applicable Out-of-Pocket Limit**.

Out-of-Network Benefits apply to Covered Health Care Services that are provided by an out-of-Network Physician or other out-of-Network provider, or Covered Health Care Services that are provided at an out-of-Network facility.

Depending on the geographic area and the service you receive, you may have access through the Claims Administrator's Shared Savings Program to Out-of-Network providers who have agreed to discount their billed charges for Covered Health Care Services. Refer to the definition of Shared Savings Program in Section 15: Glossary for details about how the Shared Savings Program applies.

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

If there is a conflict between this Schedule of Benefits and any summaries provided to you by the LAKE SAINT LOUIS COMMUNITY, this Schedule of Benefits will control.

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

Prior Authorization Requirements

The Claims Administrator requires prior authorization for certain covered expenses. In general, when services or supplies are received from a network provider, the network provider is responsible for obtaining the prior authorization. There are some Benefits, however, for which you are responsible for obtaining prior authorization.

You may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers have obtained the required prior authorization.

When services or supplies are received from an Out-of-Network provider, you are responsible for obtaining the prior authorization. Services and supplies for which you are responsible for obtaining prior authorization are listed below.

Note that your obligation to obtain prior authorization is also applicable when an Out-of-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

Failure to obtain prior authorization will result in a reduction of benefits. Reduced benefits will be 50% of Allowed Amounts. Obtaining prior authorization does not guarantee payment. Please see the Prior Authorization provision for more information.

To obtain prior authorization, call the telephone number on your ID card. This call starts the utilization review process.

Covered Health Care Services Which Require Prior Authorization

Ambulance, non-emergency
You must obtain authorization for non-emergency ambulance transportation as soon as possible prior to transport.

Cellular and Gene Therapy
For Network and Out-of-Network Benefits, you must obtain prior authorization as soon as the possibility of a Cellular or Gene Therapy arises.

At the time you seek to obtain prior authorization for a Cellular or Gene Therapy, the Claims Administrator will discuss with you the health care and financial advantages of using the services of a Designated Provider.

Clinical Trials
You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.

Dental Services - Accident Only
For network and out-of-network benefits, you must obtain prior authorization 5 business days before follow up (post-emergency) treatment begins. You do not have to obtain prior authorization before the initial emergency treatment.

Diabetes Equipment
For out-of-network benefits, you must obtain prior authorization before obtaining any equipment, for the management and treatment of diabetes, that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).

Durable Medical Equipment, Orthotics and Supplies
For out-of-network benefits, you must obtain prior authorization before obtaining any durable medical equipment that exceeds $1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).

Gender Dysphoria
For Out-of-Network Benefits for surgical treatment, you must obtain prior authorization as soon as the possibility of surgery arises and you must contact the telephone number listed on your id card 24 hours before admission for an Inpatient Stay.

For Out-of-Network Benefits for non-surgical treatment, depending upon where the Covered Health Care Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.

Habilitative Services
For out-of-network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions.

Home Health Care
For out-of-network benefits, you must obtain prior authorization 5 business days before receiving home health care services, or as soon as reasonably possible.

Hospice Care - Inpatient
For out-of-network benefits, you must obtain prior authorization 5 business days before admission for an inpatient stay in a hospice, or as soon as reasonably possible.

Hospital Inpatient Stay
For out-of-network benefits, you must obtain prior authorization 5 business days before a scheduled admission, or as soon as is reasonably possible for a non-scheduled admission, including emergency admissions.

Lab, X-Ray and Diagnostic - Outpatient
For out-of-network benefits, you must obtain prior authorization 5 business days before scheduled services are received; or for non-scheduled services, within one business day or as soon as is reasonably possible.

Major Diagnostic and Imaging
For out-of-network benefits, you must obtain prior authorization 5 business days before scheduled services are received; or for non-scheduled services, within one business day or as soon as is reasonably possible.

Maternity Services
For out-of-network benefits, you must obtain prior authorization as soon as reasonably possible if the inpatient stay for the mother and/or the newborn will be more than 48 hours following a normal vaginal delivery or more than 96 hours following a caesarean section delivery.

Mental Health Care Services and Substance-Related and Addictive Disorders Services
For out-of-network benefits for inpatient services (including services at a Residential Treatment facility), you must obtain prior authorization before a scheduled admission, or as soon as is reasonably possible for a non-scheduled admission, including emergency admissions.

For out-of-network benefits for outpatient services, you must obtain prior authorization before receiving the following services: partial hospitalization/day treatment, intensive outpatient treatment programs; electro-convulsive treatment; psychological testing; or extended outpatient treatment visits with or without medication management or medication assisted treatment programs for substance-related and addictive disorders; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*.

Outpatient Surgery
For out-of-network benefits for outpatient surgery, you must obtain prior authorization 5 business days before receiving scheduled services; or for non-scheduled services, within one business day or as soon as is reasonably possible.

Pharmaceutical Products
For out-of-network Benefits you must obtain prior authorization five business days before certain Pharmaceutical Products are received, or for non-scheduled services, within one business day or as soon as is reasonably possible.

Prosthetic Devices
For out-of-network benefits, you must obtain prior authorization before obtaining prosthetic devices that exceed $1,000 in cost per device.

Reconstructive Procedures, including breast reconstruction surgery following mastectomy
For out-of-network benefits for outpatient surgery, you must obtain prior authorization 5 business days before a scheduled reconstructive surgery is performed; or for non-scheduled reconstructive surgery, within one business day or as soon as is reasonably possible.

Rehabilitation and Inpatient Rehabilitation Facility Services/Skilled Nursing Facility
For out-of-network benefits for inpatient rehabilitation or confinement in an extended care facility, you must obtain prior authorization 5 business days before a scheduled admission; or as soon as is reasonably possible prior to a non-scheduled admission.

Therapeutic Treatments
For out-of-network benefits, you must obtain prior authorization for dialysis, intravenous chemotherapy, other intravenous infusion therapy, radiation therapy, or MR-guided focused ultrasound 5 business days before scheduled services are received; or for non-scheduled services, within one business day or as soon as is reasonably possible.

Transplants
For network and out-of-network benefits, you must obtain prior authorization as soon as the possibility of a transplant arises and before the time a pre-transplant evaluation is performed at a transplant center.

At the time you seek to obtain prior authorization for a transplant, the Claims Administrator will discuss with you the health care and financial advantages of using the services of a designated facility.

Benefits

Annual Deductibles are calculated on a Calendar Year basis.

Out-of-Pocket Limits are calculated on a Calendar Year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Out-of-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a Calendar Year basis unless otherwise specifically stated.

Annual Deductible

The Annual Deductible is the amount you must pay for Covered Health Care Services per Calendar Year before you are eligible to receive Benefits. The Annual Deductible applies to Covered Health Care Services under the Plan as indicated in this Schedule of Benefits.

The amount that is applied to the Annual Deductible is calculated on the basis of Allowed Amounts. The Annual Deductible does not include any amount that exceeds Allowed Amounts. Details about the way in which Allowed Amounts are determined appear in the definition of "Allowed Amounts" in Section 15, Glossary.

The Annual Deductible does not include any applicable copayment.

	Network	***Out-of-Network***
Individual deductible	$3,000 per Covered Person per Calendar Year	$6,000 per Covered Person per Calendar Year
Family deductible	An aggregate of $6,000 of Allowed Amounts per Calendar Year	An aggregate of $12,000 of Allowed Amounts per Calendar Year

Deductible Carryover from Prior Carrier

If the Plan Sponsor terminated a prior medical plan with another carrier, and the Plan participant and any of their Dependents were covered by that prior plan on the day immediately prior to the date when the Plan participant's coverage under this plan became effective, then the plan will adjust the Calendar Year deductible under this plan as follows:

- the Deductible Amount under this plan will be credited to the extent that, expenses incurred under the prior plan had been applied against a similar deductible amount under that prior plan, even if the prior plan deductible amount had not been fully satisfied;

- Covered Health Care Services must apply to the deductible amount under this plan for the same Calendar Year that the Plan participant and their Dependents became effective under this plan.

All or part of the current Calendar Year deductible satisfied under the prior medical plan will be applied against the current deductible amount in this plan. Any amount of expenses incurred under the prior plan and in excess of the deductible amount in this plan will be denied.

Out-of-Pocket Limit

The Out-of-Pocket Limit is the maximum you pay per Calendar Year for the Annual Deductible, Copayments and Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that Calendar Year. The Out-of-Pocket Limit applies to Covered Health Services as indicated in this Schedule of Benefits, including Covered Health Services provided under Section 13, Prescription Drug.

Details about the way in which Allowed Amounts are determined appear in the definition of "Allowed Amounts" in Section 15, Glossary.

The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:

- Any charges for non-Covered Health Services.
- The amount you are required to pay if you do not obtain prior authorization.
- Charges that exceed Allowed Amounts.

	Network	***Out-of-Network***
Out-of-Pocket Limit	$5,500 per Covered Person, not to exceed $11,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.	$11,000 per Covered Person, not to exceed $22,000 for all Covered Persons in a family. The Out-of-Pocket Limit includes the Annual Deductible.

Covered Health Care Service	Network	Out-of-Network
Ambulance Services		
Ground Ambulance	deductible then 100%	deductible then 50%***
Air Ambulance	deductible then 100%	deductible then 50%***
Cellular and Gene Therapy	deductible then 100%	deductible then 50%
Chiropractic Treatment Limited to 20 visits of Chiropractic Treatment per Calendar Year.	$30 Copayment* then 100%	deductible then 50%
Clinical Trials	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Dental Services - Accident Only or Impacted Wisdom Teeth	deductible then 100%	deductible then 50%
Diabetes Services	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Durable Medical Equipment (DME), Orthotics, Supplies and Ostomy Supplies	deductible then 100%	deductible then 50%
Emergency Health Care Services		

Allowed Amounts for Emergency Health Care Services provided by an out-of-Network provider will be determined as described below under Allowed Amounts in Section 15 Glossary. As a result, you will be responsible for the difference between the amount billed by the out-of-Network provider and the amount the Claims Administrator determines to be the Allowed Amount for reimbursement.

Physician	deductible then 100%	deductible then 100%***
Facility	$300 Copayment* then deductible then 100%	$300 Copayment* then deductible then 100%***
Gender Dysphoria	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.

Covered Health Care Service	Network	Out-of-Network
Hearing Aids ***Note:*** For enrolled Dependent children under the age of 18: One hearing aid, per hearing impaired ear every 36 months. ***Note:*** Age 18 and over: Limited to $5,000 in Allowed Amounts per Covered Person every 36 months.	deductible then 100%	deductible then 50%
Home Health Care Limited to 30 visits per Calendar Year. One visit equals up to four hours of skilled care services.	deductible then 100%	deductible then 50%
Hospice Care		
Inpatient Stay	deductible then 100%	deductible then 50%
Outpatient	deductible then 100%	deductible then 50%
Hospital - Inpatient Stay		
	deductible then 100%	deductible then 50%
Lab, X-Ray and Diagnostic		
Physician	deductible then 100%	deductible then 50%
Limited to 18 Presumptive Drug Tests per year.		
Limited to 18 Definitive Drug Tests per year.		
Facility	deductible then 100%	deductible then 50%
Note: This benefit does not include Lab, X-Ray, and other diagnostics performed as part of Emergency Health Care Services.		
Major Diagnostic and Imaging		
Physician	deductible then 100%	deductible then 50%
Facility	deductible then 100%	deductible then 50%
Maternity Services ***Note:*** A Deductible will not apply for a newborn child with a length of stay in the Hospital the same as the mother's length of stay and the mother is covered on the plan.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.

Covered Health Care Service	Network	Out-of-Network
Mental Health Care and Substance-Related and Addictive Disorders Services		
Primary Care Physician	$30 Copayment* then 100%	deductible then 50%
Specialist	$60 Copayment* then 100%	deductible then 50%
Inpatient Facility	deductible then 100%	deductible then 50%
Outpatient Facility	deductible then 100%	deductible then 50%
Partial Hospitalization / Intensive Outpatient Treatment	deductible then 100%	deductible then 50%
Residential Treatment Facility Limited to 60 days per Calendar Year combined with Skilled Nursing Facility and Inpatient Rehabilitation Facility limit.	deductible then 100%	deductible then 50%
Pharmaceutical Products	deductible then 100%	deductible then 50%
Physician Fees for Surgical Services	deductible then 100%	deductible then 50%
Physician's Visit - Sickness and Injury		
Primary Care Physician	$30 Copayment* then 100%	deductible then 50%
Specialist Physician	$60 Copayment* then 100%	deductible then 50%
Preventive Care Services		
Physician office services	100%	deductible then 50%
Lab, X-ray or other Preventive tests	100%	deductible then 50%
Breast Pumps	100%	deductible then 50%
Prosthetic Devices	deductible then 100%	deductible then 50%
Reconstructive Procedures	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.
Rehabilitation and Habilitative Services Any combination of outpatient rehabilitation and habilitative services is limited to 30 visits per Calendar Year.	deductible then 100%	deductible then 50%

Covered Health Care Service	Network	Out-of-Network
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services		
Limited to 60 days per Calendar Year combined with Residential Treatment Facility limit.	deductible then 100%	deductible then 50%
Surgery - Outpatient Facility	deductible then 100%	deductible then 50%
Therapeutic Treatments	deductible then 100%	deductible then 50%
Transplantation Services		
For Network Benefits, transplantation services must be received at a Designated Facility. The Claims Administrator does not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits. ***Note:*** The transplant network is different than the plan provider Network. Any transplant services outside of the Designated Facilities, including PPO providers and facilities, are considered out-of-network and NOT covered under the plan. To ensure Network Benefits, you must notify the Claims Administrator as soon as possibility of a transplant arises and before pre-transplantation evaluation. ***Note:*** Travel Expenses for a transplant are limited to $5,000 per transplant.	deductible then 100%	Not covered
Urgent Care Center Services		
Physician	$100 Copayment** then 100%	deductible then 50%
Facility	$100 Copayment** then 100%	deductible then 50%

*For the above services this means only one Copayment will apply for all covered services rendered by the same provider during the same visit, confinement or occurrence.

**For the above services this means only one Copayment will apply for all covered services rendered during the same visit or occurrence.

***Emergency services by an Out-of-Network provider will be considered at the Network benefit level.

Provider Network

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available online on the Claim Administrator's website or by calling Customer Service at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The Network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

There is not a guarantee that any Network provider will continue to be part of the Network. Termination of a Network Provider from the Network, or termination of the Network contract, is made without prior approval from the Employer or from you.

When a Network provider terminates from a Network or a Network contract terminates, the Claims Administrator will make reasonable efforts to replace the terminated contract with a new Network contract. However, there is no guarantee that this will happen.

If you are currently undergoing a course of treatment utilizing an out-of-network Physician or health care facility, you may be eligible to receive Transition of Care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for Transition of Care Benefits, please contact the telephone number on your ID card.

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

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at either a Network Pharmacy or Out-of-Network Pharmacy and are subject to Copayments, Annual Deductibles, and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed. If you use an Out-of-Network pharmacy, (including mail order), you may be responsible for any amount over the allowed amount.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service. Refer to Section 13, Prescription Drug for further coverage and exclusion information.

What Do You Pay?

You are responsible for paying the applicable Copayment, Annual Deductible and/or Coinsurance. Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible, Copayments and/or Coinsurance.

The amount you pay for the following under Section 13, Prescription Drug will not be included in calculating any Out-of-Pocket Limit:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. The Claims Administrator's contracted rates (the Claims Administrator's Prescription Drug Cost) will not be available to you.

- The difference between the Out-of-Network Reimbursement Rate and an Out-of-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.

An Ancillary Charge may apply when a covered prescription drug product is dispensed at your or the provider’s request and there is another drug that is chemically the same available. An Ancillary Charge does not apply to any Out-of-Pocket Limit.

Payment Information

Annual Deductible

The amount that is applied to the Annual Deductible is calculated on the basis of Allowed Amounts. The Annual Deductible does not include any amount that exceeds Allowed Amounts.

Individual deductible	None
Family deductible	None

NOTE: Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of the Annual Deductible.

Copayment

Copayment for a Prescription Drug Product at a Network or Out-of-Network Pharmacy is a specific dollar amount.

Coinsurance

Coinsurance for a Prescription Drug Product at a Network or Out-of-Network Pharmacy is a percentage of the Prescription Drug Cost.

Copayment and Coinsurance

Your Copayment and/or Coinsurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product.

Special Programs: The Claims Administrator may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication regimens. You may access information on these programs by contacting the Claims Administrator at www.myallsaversconnect.com or the telephone number on your ID card.

NOTE: The tier placement of a Prescription Drug Product can change from time to time. These changes generally happen twice a year, but no more than six times per Calendar Year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact the Claims Administrator at www.myallsaversconnect.com or the telephone number on your ID card for the most up-to-date tier status.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copayment, Annual Deductible, and/or Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.
- The Prescription Drug Cost for that Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copayment, Annual Deductible, and/or Coinsurance.
- The Prescription Drug Cost for that Prescription Drug Product.

See the Copayments, Annual Deductible, and/or Coinsurance stated in the Benefit Information table for amounts.

NOTE: Benefits for PPACA Zero Cost Share Preventive Care Medications are not subject to payment of Copayments, Annual Deductible, and/or Coinsurance.

Benefit Information

Prescription Drugs from a Retail Network or Out-of-Network Pharmacy

The following supply limits apply:

- As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copayment, Annual Deductible, and/or Coinsurance that applies will reflect the number of days dispensed.

If the Prescription Drug Product is dispensed by a retail out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with the Claims Administrator. The Plan will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. The Plan will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy.

Your Copayment, Annual Deductible, and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, Tier-3, or Tier-4. Please contact the Claims Administrator at www.myallsaversconnect.com or the telephone number on your ID card to determine tier status.

For a Tier-1 Prescription Drug Product:
$15 copay

For a Tier-2 Prescription Drug Product:
$35 copay

For a Tier-3 Prescription Drug Product:
$75 copay

For a Tier-4 Prescription Drug Product:
$250 copay

Prescription Drug Products from a Mail Order Network or Out-of-Network Pharmacy

The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- You may be required to fill the first Prescription Drug Product order and get 1-3 refills through a retail pharmacy using a Mail Order Network or Out-of-Network Pharmacy.

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 Copayment, Annual Deductible, and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.

If the Prescription Drug Product is dispensed by a Mail Order out-of-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed. You can file a claim for reimbursement with the Claims Administrator. The Plan will not reimburse you for the difference between the Out-of-Network Reimbursement Rate and the out-of-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. The Plan will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from an out-of-Network Pharmacy

Your Copayment, Annual Deductible, and/or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, Tier-3, or Tier-4. Please contact the Claims Administrator at www.myallsaversconnect.com or the telephone number on your ID card to determine tier status.

For a Tier-1 Prescription Drug Product:
$38 copay

For a Tier-2 Prescription Drug Product:
$88 copay

For a Tier-3 Prescription Drug Product:
$188 copay

For a Tier-4 Prescription Drug Product:
$625 copay

SECTION 5 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Care Services for which the Plan pays Benefits.

This section supplements Section 4, Schedule of Benefits.

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. The Covered Health Care Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 6, Exclusions: What the Plan Will Not Cover.

Acupuncture Services

Acupuncture services provided in an office setting for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Benefits are provided regardless of whether the office is free-standing, located in a clinic or located in a Hospital.

Acupuncture services must be performed by a provider who is either:

- Practicing within the scope of his/her license (if state license is available); or
- Certified by a national accrediting body.

Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.

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

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

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

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a long term Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

Cellular and Gene Therapy

Cellular and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office. Benefits for CAR-T therapy for malignancies are provided as described under Transplantation Services.

Chiropractic Treatment

Manipulative therapy to restore normal function to the nerve system and body structures including, but not limited to:

- Manipulation;
- Myofascial release; or
- Soft tissue mobilization.

Benefits are available for the cost to evaluate the need and extent of these therapies.

Benefits do not include:

- Maintenance care;
- Treatment and services for community re-entry;
- Supervised living;
- Residential living programs; or
- Work-hardening programs.

Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Care Services needed for reasonable and needed care arising from the receipt 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.
    - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies.

- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person taking part in the trial.

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

With respect to cardiovascular disease 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. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It meets any of the following criteria in the bulleted list below.

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

Dental Services - Accident Only or Impacted Wisdom Teeth

Accident Only dental services when both of the following are true:

- Treatment is needed because of accidental damage;
- You receive dental services from a Doctor of Dental Surgery or Doctor of Medical Dentistry; and

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

Please note that dental happens due to normal activities of daily living or extraordinary use of the teeth is not considered an accident injury. Benefits are not available for repairs to teeth that are damaged due to such activities.

Dental services to repair damage caused by accidental Injury must follow these timeframes:

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

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

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

The Plan also covers dental care required for the direct treatment of an impacted wisdom tooth.

Diabetes Services

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

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

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

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon your medical needs including, but not limited to the following:

- Continuous blood glucose monitors;
- Insulin syringes with needles;
- Blood glucose and urine test strips;
- Ketone test strips and tablets; or
- Lancets and lancet devices.

Insulin pumps are subject to all the conditions of coverage stated under Durable Medical Equipment (DME), Orthotics and Supplies and Ostomy supplies.

Durable Medical Equipment (DME), Orthotics and Supplies and Ostomy Supplies

Benefits are provided for DME and certain orthotics and supplies.

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

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a walker, cane, or standard wheelchair;
- A standard hospital-type bed;
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks);
- 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.
- 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, unless prescribed by a Physician. Dental braces are also excluded from coverage;
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air–conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage);
- Burn garments; and
- Insulin pumps and all related needed supplies as described under Diabetes Services.

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

Benefits do not include any device, appliance, pump machine, stimulator, or monitor that is fully implanted into the body.

Orthotics

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

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

Benefits are available for repairs and replacement, except as described in Section 6: Exclusions:

Benefits for ostomy supplies are limited to the following:

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

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

Emergency Health Care Services

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility. Emergency Health Care Services are

available 24 hours per day, seven days per week. If you require Emergency Health Care Services, go to the nearest emergency room or call 911 for help.

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

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

***Note*:** If you are confined in an out-of-Network Hospital after you receive outpatient Emergency Health Care Services, you must obtain prior authorization within one business day or on the same day of admission if reasonably possible.

Gender Dysphoria

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

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

Hearing Aids

Hearing Aids required for the correction of a Hearing Impairment and charges for related fitting and testing. The Hearing Aid must be purchased due to a written recommendation by a Physician.

Covered Health Care Services are limited to a single purchase, including repair/replacement, every 36 months.

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

Benefits for bone anchored hearing aids (BAHA) are a Covered Health Care Service for which Benefits are provided under the applicable medical/surgical benefit categories in the Summary Plan Description. They are only available if you have either of the following:

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

Benefits for BAHA are limited to one per Covered Person during the entire period of time the Covered Person is enrolled under the Plan and include repairs and/or replacement only if the BAHA malfunctions

Home Health Care

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

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

Hospice Care

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

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

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

Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay; and
- Room and board in a Semi-Private Room

Lab, X-Ray and Diagnostic

Services for Sickness and Injury-related diagnostic purposes, received at a Hospital or Alternate Facility or in a Physician's office include, but are not limited to:

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

Benefits include:

- The physician and facility charge; and
- The charge for supplies and equipment.

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

Major Diagnostic and Imaging

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

Benefits include:

- The physician and facility charge; and
- The charge for supplies and equipment

Maternity Services

Benefits for Covered Health Care Services incurred by you or your Enrolled Dependent Spouse or daughter for a normal Pregnancy and for childbirth. Benefits include Covered Health Care Services for a cesarean section.

The plan will provide these Benefits on the same basis as they pay for Benefits for a Sickness, according to:

- Guidelines established by the American College of Obstetricians and Gynecologists; or
- Any other established professional medical association.

For inpatient care at a Hospital, the plan will provide Benefits for the mother for up to:

- 48 hours following a vaginal delivery; or
- 96 hours following an elective or scheduled cesarean section.

The mother is not required:

- To give birth in a Hospital; or
- To stay in the Hospital for these minimum hours.

The above hours do not prohibit the mother and her Physician from both deciding on an earlier discharge.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery. If delivery happens outside of a Hospital, the 48 or 96 hours begin when the mother is admitted to the Hospital for the birth. A determination of whether to admit the mother to a Hospital for childbirth is made by the Physician.

For purposes of this provision, a Physician may be a person such as a nurse midwife or a physician assistant, who is:

- Licensed under applicable state law to provide maternity care;

- Directly responsible for providing maternity care to the mother; and
- Providing the care.

For purposes of this provision, a Hospital includes a licensed, free-standing birthing facility that provides services for:

- Prenatal care;
- Delivery;
- Immediate postpartum care; and
- Care of the child born at the center.

Covered Health Care Services incurred at a free standing birthing facility are provided on the same basis as maternity Benefits received at a Hospital. The same inpatient care time periods apply for maternity care received at a free standing birthing facility as for similar care received at a Hospital.

The plan will provide Benefits for Complications of Pregnancy the same as for a Sickness.

Follow-up Care

The plan will provide Benefits for Physician-directed follow-up care on the same basis as it pays for Benefits for a Sickness.

Follow-up care services include:

- Physical assessment of the mother and newborn;
- Parent education;
- Help and training in breast or bottle feeding;
- Assessment of the home support system;
- Performance of any Medically Necessary and appropriate clinical tests; and
- Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

Benefits apply to services provided in a medical setting or through home health care visits. Benefits apply to a home health care visit only if the health care provider who conducts the visit is knowledgeable and experienced in maternity and newborn care.

When the mother and her Physician decide to shorten the length of the Inpatient Stay to less than the number of hours required under this maternity benefit and the newborn well baby care benefit, the plan will provide Benefits for all follow-up care that is provided within 72 hours after discharge.

When the mother or newborn receives at least the number of hours of inpatient care required to be covered, the plan will only provide Benefits for follow-up care that is determined to be Medically Necessary by the health care provider responsible for discharging the mother or newborn.

Newborn Well Baby Care

Benefits for newborn well baby care are provided on the same basis as Benefits for a Sickness.

The plan will provide Benefits for newborn well baby care that meets the definition of a preventive care service.

The plan will provide Benefits for newborn well baby care according to:

- Guidelines established by the American Academy of Pediatrics; or
- Any other established professional medical association.

Newborn well baby care services include:

- Hospital nursery room, board and miscellaneous services and supplies provided and billed by the Hospital on its own behalf;
- Physician charges for circumcision; and
- Physician charges for the first routine exam of the child before discharge from the Hospital.

The plan will provide Benefits for newborn well baby care for up to:

- 48 hours of the child's life for a vaginal delivery; or
- 96 hours of the child's life for a cesarean section,

However, the plan will never provide benefits for newborn well baby care after the mother is discharged from the Hospital.

For multiple births, the 48 or 96 hours begin at the time of the last child's delivery.

These are federally mandated requirements under the Newborn's 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.

If delivery happens outside of a Hospital, the 48 or 96 hours begin when the newborn is admitted to the Hospital for the birth. A determination of whether to admit the newborn to a Hospital is made by the Physician.

For purposes of this provision, a Physician is a person who is:

- Licensed under applicable state law to provide pediatric care;
- Directly responsible for providing pediatric care to the child; and
- Providing the care.

IMPORTANT: To provide coverage for the child, (Including Newborn Well Baby Care), you must enroll the child under the plan as required under adding new dependents in Section 2, Introduction sub-section When Coverage Begins. Failure to enroll will result in no coverage for the newborn under this plan.

Mental Health Care and Substance Related and Addictive Disorder Services

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

Benefits include the following levels of care:

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

Benefits will be provided for the following Covered Health Care Services to treat a Mental Health Condition:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy and provider-based case management services.
- Crisis intervention.
- Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as Applied Behavioral Analysis (ABA) that are the following:

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

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

The Plan determines coverage for all levels of care. If an Inpatient Stay or Residential Treatment is required, it is covered on a Semi-Private Room basis (a room with two or more beds).

Pharmaceutical Products

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

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

Physician Fees for Surgical Services

Covered Health Care Services include Physician fees for surgical procedures received on an outpatient or inpatient basis in a Physician’s Office, Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility.

Benefits under this provision include fees for services provided by a Physician surgical assistant and/or a non–Physician surgical assistant. When multiple surgical procedures are done at the same time, Covered Health Care Services will include the Allowed Amount for the first or major procedure and one-half of the Allowed Amount for each additional procedure. For a Physician surgical assistant, payment is limited to 20% of the Allowed Amount for the first or major surgical procedure and 10% of the Allowed Amount for additional procedures. For a non-Physician surgical assistant, payment is limited to 10% of the Allowed Amount for the first or major procedure and 5% of the Allowed Amount for each additional procedure.

Benefits also include anesthesia services.

Benefits are not payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

Physician's Visit - Sickness and Injury

Services provided by a Physician for the diagnosis and treatment of a Sickness or Injury received on an outpatient or inpatient basis. Benefits are provided under this section regardless of whether the service is rendered in a clinic, Skilled Nursing Facility, Alternate Facility or Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is a part of treatment; and
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Covered Health Care Services include Genetic Counseling. Benefits include genetic testing which results in available medical treatment options and is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by the Claims Administrator.

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

Benefits also include a second opinion.

Each Physician who gives a second opinion:

- Must be a specialist for the Injury or Sickness; and
- Cannot be financially connected with the other Physician(s).

Preventive Care Services

Benefits are provided for services for preventive medical care provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital for:

- Items or services that have an A or B rating in current recommendations of the United States preventive Services Task Force;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supports by the Health Resources and Services Administration (HRSA); and
- Additional preventive care and screening, with respect to women, provided for in guidelines supported by HRSA.

Benefits defined under this requirement include one breast pump per Pregnancy in conjunction with childbirth. If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented (and the duration of any rental).

Examples of preventive medical care are:

Physician office services:

- Routine physical examinations;
- Well baby and well child care;
- Immunizations and;
- Hearing screening.

Lab, X-ray or other preventive tests:

- Cervical cancer screening;
- Prostate cancer screening; and
- Bone mineral density tests.

Prosthetic Devices

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

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

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

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

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

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect; and
- There are no Benefits for replacement due to misuse, malicious damage, and gross neglect or for lost or stolen prosthetic devices.

Reconstructive Procedures

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

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

Reconstructive procedures include surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

Note: Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications at all stages of mastectomy including lymph edemas, are provided in the same manner and at the same level as those for any other Covered Health Care Service.

Rehabilitation and Habilitative Services - Outpatient Therapy

Short-term outpatient rehabilitation services, including habilitative services, limited to:

- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Pulmonary rehabilitation therapy;
- Cardiac rehabilitation therapy; and
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy

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

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

- You are not progressing in goal-directed rehabilitation services, or

- Rehabilitation goals have previously been met.

For outpatient rehabilitative services for speech therapy, the plan will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer or Congenital Anomaly.

Habilitative Services

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

Habilitative services are limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive therapy.

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

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

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

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed. When the treating provider expects that continued treatment is or will be required to allow you to achieve progress this is capable of being demonstrated, the Claims Administrator may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, expected duration of treatment, the expected goals of treatment, and how frequently the treatment plan will be updated.

Habilitative services provided in your home by a Home Health Agency are provided as described under Home Health Care.

For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

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

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 or Congenital Anomaly. The plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

- Supplies and non-Physician services received during the Inpatient Stay; and

- Room and board in a Semi-Private Room

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

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

Surgery - Outpatient Facility

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

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

- Arthroscopy,
- Laparoscopy,
- Bronchoscopy,
- Hysteroscopy.

Benefits under this provision include the facility charge and the charge for supplies and equipment.

Therapeutic Treatments

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

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

Covered Health Care Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered health care professionals when both of the following are true:

- Education is required for a disease in which patient self–management is a part of treatment;
- There is a lack of knowledge regarding the disease which requires the help of a trained health professional.

Benefits include the facility charge and the charge for related supplies and equipment.

Transplantation Services

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

Examples of transplants for which Benefits are available include bone marrow including CAR-T cell therapy for malignancies, heart, heart/lung, lung, double lung, kidney, kidney/pancreas, liver, liver/small intestine, pancreas, bowel, small intestine and cornea.

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

- Identification.
- Evaluation.
- Organ removal.

- Direct follow-up care.

If you are required to receive transplantation services at a Designated Facility outside your geographic area, the plan will provide travel and lodging in agreement with the Claims Administrator's guidelines.

The Claims Administrator has specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the number on your ID card for information about these guidelines.

Urgent Care Center Services

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

Voluntary Sterilization Procedures

The plan will also provide Benefits for voluntary sterilization procedures for you and for your Enrolled Dependent Spouse. The plan will not provide benefits for your Enrolled Dependent child.

SECTION 6 - EXCLUSIONS: WHAT THE PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Care Services, except as may be specifically provided for in 5, 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 or are medically necessary

When Benefits are limited within any of the Covered Health Care Services categories described in 5, Additional Coverage Details, those limits are stated in the corresponding Covered Health Care Service category in Section 4, Schedule of Benefits. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in Section 4, Schedule of Benefits. 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 limited to", it is not the intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Massage therapy (This exclusion does not apply to Chiropractic Treatment and osteopathic care for which Benefits are provided as described in 5, Additional Coverage Details.);
- Rolfing (holistic tissue massage);
- Adventure based therapy, wilderness therapy and outdoor therapy, or similar programs; and
- Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health.

Dental

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

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under Dental Services - Accident Only and Impacted Wisdom Teeth in Section 5, Additional Coverage Details.

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

- Transplant preparation;
- Prior to the initiation of immunosuppressive drugs; and
- The direct treatment of cancer or cleft palate.

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

Endodontics, periodontal surgery and restorative treatment are excluded.

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

- removal, restoration and replacement of teeth;
- medical or surgical treatments of dental conditions; 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 and Impacted Wisdom Teeth in Section 5, Additional Coverage Details.

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 and Impacted Wisdom Teeth in 5, Additional Coverage Details.

Dental braces (orthodontics).

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

Devices, Appliances and Prosthetics

- Devices used as safety items or to help performance in sports–related activities.
- Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, cranial molding helmets and cranial banding except when used to avoid the need for surgery, and/or to facilitate a successful surgical outcome and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to braces for which Benefits are provided as described under Durable Medical Equipment (DME), Orthotics, Supplies and Ostomy Supplies in Section 1: Covered Health Care Services.
- The following items are excluded, even if prescribed by a Physician:
  - blood pressure cuff/monitor;
  - enuresis alarm;
  - Home coagulation testing equipment;
  - non-wearable external defibrillator;
  - trusses;
  - ultrasonic nebulizers; and
  - ventricular assist devices.
- Devices and computers to help in communication and speech except for speech aid prosthetics and trachea-esophageal voice prosthetics.
- Oral appliances for snoring.
- Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered and non-powered exoskeleton devices.

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 13, *Prescription Drugs*, for coverage details and exclusions.

- Prescription drug products for outpatient use that are filled by a prescription order or refill.
- Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

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

- Over-the-counter drugs and treatments.

- Certain new Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year. This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided in Section 5: Service Additional Coverage Details.

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

- A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.

- Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

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

- Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.

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

Experimental or Investigational Services or Unproven Services

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

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

Foot Care

- Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care if you have diabetes for which Benefits are provided as described under Diabetes Services in Section 1: Covered Health Care Services.

- Nail trimming, cutting, or debriding. This exclusion does not apply to preventive care for Covered Persons who are at risk of neurological vascular disease arising from disease such as diabetes.

- Hygienic and preventive maintenance foot care. Examples include:

  - cleaning and soaking the feet; and

  - applying skin creams in order to maintain skin tone.

  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.

- Shoes

- Shoe orthotics;
- Shoe inserts; and
- Arch supports.

Gender Dysphoria

Cosmetic Procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Breast enlargement, including augmentation mammoplasty and breast implants.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.
- Thyroid cartilage reduction, reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple).
- Voice modification surgery.
- Voice lessons and voice therapy.

Mental Health Care and Substance-Related and Addictive Services

In addition to all other exclusions listed in this Section 6: Exclusions and Limitations, the exclusions listed directly below apply to services described under Mental Health Care and Substance-Related and Addictive Services in 5: Additional Coverage Details.

- Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association.
- Outside of an assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

- Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.

- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

- Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

- Outside of an assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

- Transitional Living Services.

Nutrition

- Individual and group nutritional counseling including nonspecific nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

    - nutritional education is required for a disease in which patient self-management is an important part of treatment; and

    - there is a lack of knowledge regarding the disease which requires the help of a trained health professional.

- Food of any kind including modified food products such as low protein and low carbohydrate; enteral formula (including when administered using a pump), infant formula, and donor breast milk.

- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition–based therapy. Examples include supplements and electrolytes.

- Any product, for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury.

Personal Care, Comfort or Convenience

- Television;

- Telephone;

- Beauty/barber service;

- Guest service; and

- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:

    - Air conditioners, air purifiers and filters, dehumidifiers;
    - Batteries and battery chargers;
    - Car seats;
    - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, recliners;
    - Electric scooters;
    - Exercise equipment;
    - Home modifications such as elevators, handrails and ramps;
    - Hot tubs;
    - Humidifiers;
    - Jacuzzis;
    - Mattresses;
    - Medical alert systems;
    - Motorized beds;

- Music devices;
- Personal computers;
- Pillows;
- Power-operated vehicles;
- Radios;
- Saunas;
- Stair lifts and stair glides;
- Strollers;
- Safety equipment;
- Speech generating devices;
- Treadmills;
- Vehicle modifications such as van lifts;
- Video players; and
- Whirlpools.

Physical Appearance

- Cosmetic Procedures. See the definition in Section 15, Glossary. 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;
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures;
  - Skin abrasion procedures performed as a treatment for acne;
  - Treatment for skin wrinkles or any treatment to improve the appearance of the skin;
  - Treatment for spider veins;
  - Sclerotherapy treatment of veins; and
  - Hair removal or replacement by any means.
- Breast implants or replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the first breast implant followed mastectomy. See Reconstructive Procedures in 5, Additional Coverage Details.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Wigs regardless of the reason for the hair loss

Procedures and Treatments

- Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty, and brachioplasty.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer or Congenital Anomaly.

- Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
- Biofeedback.
- Services for the diagnosis and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature. 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; dental restorations.
- Upper and lower jawbone surgery except as required for direct treatment of sudden traumatic Injury, dislocation, tumors or cancer or as needed to safeguard your health due to a non–dental physiological impairment. Surgical and non-surgical for Orthognathic and jaw alignment disorders, except as a treatment of obstructive sleep apnea.
- Surgical and non-surgical treatment of obesity.
- Stand-alone multi-disciplinary smoking cessation programs.
- Breast reduction surgery that is determined to be a Cosmetic Procedure.
- Helicobacter pylori (H. pylori) serologic testing.
- Intracellular micronutrient testing.
- Health care services provided in an emergency department of a Hospital or Alternate Facility that are not for an Emergency.

Providers

- Services performed by a provider who is a family member by birth or marriage. Examples include a Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal address.
- Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
    - Has not been actively involved in your medical care prior to ordering the service, or
    - Is not actively involved in your medical care after the service is received.
- Foreign language and sign language interpreters.

Reproduction

- Health Care Services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
- The following services related to Gestational Carrier or Surrogate:
    - All costs related to reproductive techniques including:
        - Assistive reproductive technology;
        - Artificial insemination;
        - Intrauterine insemination; and
        - Obtaining and transferring embryo(s).
    - All fees including:
        - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees;
        - Surrogate insurance premiums; and
        - Travel or transportation fees.

- Health care services including: (This exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.)
  - Inpatient or outpatient prenatal care and/or preventive care;
  - Screenings and/or diagnostic testing; and
  - Delivery and post-natal care.

- Cost of donor eggs and donor sperm.

- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.

- The reversal of voluntary sterilization.

- Health Care Services and related expenses for surgical, non-surgical, or drug-induced pregnancy termination. This exclusion does not apply to treatment of a molar pregnancy, ectopic pregnancy, or missed abortion (commonly known as a miscarriage).

- In vitro fertilization regardless of the reason for treatment.

Services Provided under another Plan

- Health Care Services for when other coverage is required by federal, state or local law to be purchased or bought through other arrangements. Examples include coverage required by workers' compensation or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

- Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

- Health Care Services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.

- Health Care Services while on active military duty.

Transplants

- Health Care Services for organ and tissue transplants, except those described under Transplantation Services in 5, Additional Coverage Details.

- Health Care Services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.)

- Health Care Services for transplants involving animal organs.

- Transplant services that are not performed at a Designated Facility. This exclusion does not apply to cornea transplants.

Travel

- Health Care Services provided in a foreign country, unless required as Emergency Health Care Services.

- Travel or transportation expenses, even though prescribed by a Physician. This exclusion does not apply to ambulance transportation or to travel for transplantation services as described in 5, Additional Coverage Details.

Types of Care

- Multi–disciplinary pain management programs provided on an inpatient basis.

- Custodial Care.

- Domiciliary care.

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

- No skilled services are identified;
- Skilled nursing resources are available in the facility; or
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

- Respite care.
- Rest cures.
- Services of personal care aides.
- Work hardening (treatment programs designed to return a person to work or to prepare a person for specific work).

Vision

- Cost and fitting charge for eye glasses and contact lenses for vision correction or cosmetic purposes.
- Routine vision exams, including refractive exams to determine the need for vision correction.
- Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).
- Eye exercise therapy or vision therapy.
- Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

All Other Exclusions

- Health Care Services and supplies that do not meet the definition of a Covered Health Care Service - see the definition in Section 15, Glossary.
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
  - Required only for career, school, sports or camp, travel, employment, insurance, marriage or adoption;
  - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
  - Conducted for purposes of medical research; or
  - Required to obtain or maintain a license of any type.
- Health Care Services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Care Services if they are to treat complications that arise from the non-Covered Health Care Service.
- Health Care Services received after the date your coverage under the Plan ends. This applies to all Health Care Services, even if the Health Care Service is required to treat a medical condition that arose before the date your coverage under the Plan ended.
- Health Care Services received due to war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
- Health Care Services for which you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.

- In the event an out-of-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance any deductible, or other amount owed for a particular Health Care Service, no Benefits are provided for the Health Care Service for which the Copayments, Coinsurance and/or deductible are waived.
- Charges in excess of Allowed Amounts or in excess of any specified limitation.
- Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
- Autopsy.

SECTION 7 - HOW TO FILE A CLAIM

What this section includes:

- Claims mailing address
- How are Covered Health Care Services from a Network Provider Paid?
- How are Covered Health Care Services from an Out-of-Network Provider Paid?
- Notice of claim
- Claim forms
- Proof of loss
- Payment of claim
- Time of payment of claim
- Assignment of benefits

Claims Mailing Address

All Savers
P.O. Box 31375
Salt Lake City, UT 84131-0375

How Are Covered Health Care Services from Network Providers Paid?

The Claims Administrator processes payment to Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact the Claims Administrator. However, you are required to meet any applicable Annual Deductible and to pay any required Copayments and Coinsurance to a Network provider.

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

When you receive Covered Health Care Services from an out-of-Network provider, you or the out-of-Network provider is responsible for requesting payment from the Claims Administrator.

You or the out-of-Network provider should submit a request for payment of Benefits within 90 days after the date of service. If you or the out-of-Network provider do not provide this information to the Claims Administrator within 15 months of the date of service, Benefits for that health service will be denied or reduced, as the Claims Administrator determines. This time limit does not apply if you are legally incapacitated or if extenuating circumstances apply. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Notice of Claim

You must send the Claims Administrator written notice of claim within 20 days from the date when you incur a claim. Failure to give notice within the 20 days does not invalidate or reduce a claim, if you can show the Claims Administrator that it was not reasonably possible to give notice in that time, and you gave notice when reasonably possible.

The Claims Administrator requires the notice to include your name and address and the name of the person who incurred the claim.

Claim Forms

The Claims Administrator does not require claim forms for medical coverage. However, one may be required for other types of insurance. The Claims Administrator will provide you with any claim form required within 15 days from the date the Claims Administrator receives notice of claim. If a claim form is not provided in that time, you can meet the proof of loss requirement by sending the Claims Administrator facts about the nature and extent of the claim.

Proof of Loss

The Plan requires written proof of loss. A written proof of loss is a bill from a health care provider. The Plan must receive the proof within 90 days from the date of loss.

Failure to send the proof of loss in that time does not invalidate or reduce a claim if you can show that it was not reasonably possible to send proof of loss in that time, and you sent it when reasonably possible.

In any event, the Claims Administrator must receive the proof of loss not later than 15 months from the date of loss, unless you are not legally competent to send it during that time.

Payment of Claim

The Plan has the authority to automatically pay Benefits to Physicians or other providers. After the plan pays, they are discharged from paying any further Benefits to the extent of what it has already paid.

If you want to receive direct payment of Benefits, you must notify the Claims Administrator before they receive proof of loss.

The Plan may be required to pay Benefits to your estate, to your Dependent's estate, or to someone who is a minor or is otherwise not legally competent. When this happens, the Plan may pay an amount not to exceed $1,000 to a family member who it believe is equitably entitled to that amount. Any payment made in good faith fully discharges the Plan, to the extent of that payment.

If the Claims Administrator has documented proof that:

- A Physician or other provider waived from their total fees a Copayment, Annual Deductible or Coinsurance amount that you are otherwise required to pay under the plan; then
- The Plan has the right to reduce the benefit amount the plan pays by the amounts waived by the Physician or other provider.

Time of Payment of Claim

The plan will pay or deny a claim when a claim is received that includes all of the information needed to process.

If additional supporting information is required to process the claim, the Plan will notify the applicable person(s). This notice will detail the supporting documentation needed.

As applicable, the provider or both you and the provider will be notified when a claim is denied. The notification will include the reason(s) for the denial.

Assignment of Benefits

Except as described under the Payment of Claim provision, you cannot assign any other rights to another party.

SECTION 8 - QUESTIONS, COMPLAINTS AND APPEALS

What this section includes:

- What if You Have a Question?;
- What if You have a Complaint?;
- How Do You Appeal a Claim Decision?;
- Appeal process;
- Appeals Determinations;
- Urgent appeals that require immediate action;
- Federal external review program;
- Standard external review;
- Expedited external review; and
- Appeals of other than adverse benefit determinations.

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

What if You Have a Question?

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

What if You Have a Complaint?

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

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

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

How Do You Appeal a Claim Decision?

Post-service Claims

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

Pre-service Requests for Benefits

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

How to Request an Appeal

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

For non-urgent appeals, you may contact the Plan at:

Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Fax: 801-478-5463
Phone: 800-291-2634

If you feel your situation is urgent, you may request an expedited (urgent) appeal orally, by fax or in writing at:

Grievance Administrator
3100 AMS Blvd.
Green Bay, WI 54313
Fax: 866-654-6323
Phone: 800-291-2634

Your request for an appeal should include:

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

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

Appeal Process

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

Appeals Determinations

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

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

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

For appeals of pre-service requests for Benefits you will be notified of the decision within 15 days from receipt of a request for a first level appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. You will be notified of the decision within 15 days from receipt of a request for review of the second level appeal decision.

For appeals of post-service claims you will be notified of the decision within 30 days from receipt of a request for a first level appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. You will be notified of the decision within 30 days from receipt of a request for review of the second level appeal decision.

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

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

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain.

In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.

The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

If the Claims Administrator needs more information from your Physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

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

Federal External Review Program

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

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

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

- Clinical reasons.
- The exclusions for Experimental or Investigational Services or Unproven Services.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

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

An external review request should include all of the following:

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

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

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

Standard External Review

A standard external review includes all of the following:

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

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

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

After the Claims Administrator completes this review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign as IRO to conduct such review. The Claims Administrator will assign requests by either rotating 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.

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

The documents include:

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

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

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

Expedited External Review

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

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

- An adverse benefit determination of a claim or appeal 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.
    - The individual's ability to regain maximum function.
    - If you have filed a request for an expedited internal appeal.

- A final appeal decision, that either:

    - Involves a medical condition where the timeframe completion of a standard external review would either jeopardize the life or health of the individual or jeopardize the individual's ability to regain maximum function.

    - Concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency care services, but has not been discharged from a facility.

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

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.

- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes the review, the Claims Administrator will send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator will assign an IRO in the same manner the Claims Administrator used to assign standard external reviews to IRO*s*. The Claims Administrator will provide documents and information used in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available 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 as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the IRO's final external review decision is first communicated verbally, the IRO will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

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

Timing of Appeals Determinations

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

- Urgent care request for Benefits- a request for Benefits provided in connection with urgent care services.

- Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify Claims Administrator before non-urgent care is provided.

- Service - a claim for reimbursement of the cost of non-urgent care that has already been provided.

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

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

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

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to Claims Administrator within:	48 hours after receiving notice of additional information required

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
Claims Administrator must notify you of the benefit determination after receiving additional information within:	48 hours of receipt of the information or the end of the period provided to provide the additional information
Claims Administrator must notify you of the benefit determination within:	72 hours
If Claims Administrator denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

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

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to Claims Administrator within:	45 days
Claims Administrator must notify you of the benefit determination:	
if the initial request for Benefits is complete, within:	15 days
after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Claims Administrator must notify you of the second level appeal decision within:	15 days after receiving the second level appeal*

*Claims Administrator may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

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

Post-Service Claims	
Type of Claim or Appeal	**Timing**
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Claims Administrator must notify you of the second level appeal decision within:	30 days after receiving the second level appeal*

*Claims Administrator may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Appeals of Other Than Adverse Benefit Determinations

If you or your authorized representative disagree with a determination other than those described under the procedures above, you or your authorized representative may ask to have it reviewed.

A written request should be sent to the Claims Administrator within 180 calendar days of the date you or your authorized representative receive the adverse determination. The appeal may include:

- written comments, documents, records, and other information relating to the determination; and
- the ID numbers on your insured ID card.

Please state the reason(s) you or your authorized representative disagree with the determination and include all information that may support the appeal.

The Claims Administrator will notify you or your authorized representative of the decision within 30 days of the Claims Administrator's receipt of the appeal request. If the Claims Administrator denies your first appeal, a second appeal may be requested using the same procedures as required for the first. The Claims Administrator will respond to the second appeal within 30 days of the Claims Administrator's receipt of the second appeal request; this completion of the second appeal will exhaust the appeal process.

SECTION 9 - COORDINATION OF BENEFITS (COB)

What this section includes:

- Benefits When You Have Coverage under More than One Plan
- Definitions
- What Are the Rules for Determining the Order of Benefit Payments?
- How Are Benefits Paid When This Plan is Secondary to Medicare?

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

Definitions

For purposes of this section, terms are defined as follows:

A. **Plan**. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan**. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

D. **Allowable Expense**. Allowable Expense is a health care expense, including deductibles, co-insurance and Co-payments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or according to contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar

reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include precertification of admissions and preferred provider arrangements.

E. Closed Panel Plan. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

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

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

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

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

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

C. A plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;

D. If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

E. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

F. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

G. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

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

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

covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

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

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

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

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

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

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

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

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

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

         (a) The Plan covering the Custodial Parent.

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

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

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

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

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

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

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

4. **COBRA or State Continuation Coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage. is the Secondary Plan. If the other Plan does

not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled H.1. can determine the order of benefits.

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

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

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

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

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

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, the Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Does This Plan Have the Right of Recovery?

If the amount of the payments made is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons paid or for whom the Plan have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

How Are Benefits Paid When This Plan is Secondary to Medicare?

If This Plan is secondary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced 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.

SECTION 10 - SUBROGATION AND REIMBURSEMENT; RETURN OF OVERPAYMENTS

What this section includes:

- Right of recovery;
- Right to subrogation;
- Right to reimbursement;
- Third parties;
- Subrogation and reimbursement provisions; and
- Refund of overpayments.

The Plan has a right to subrogation and reimbursement, as defined below.

Right of Recovery

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

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

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you or your dependents may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered responsible. Subrogation applies when the Plan has paid benefits on your or your dependents behalf for a Sickness or Injury for which a third party is considered responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your or your dependents behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a Sickness or Injury for which you or your dependents receive a settlement, judgment, or other recovery from any third party, you or your dependents must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you or your dependent 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;
- LAKE SAINT LOUIS COMMUNITY in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you or your dependent with benefits or payments under:
- underinsured or uninsured motorist insurance;
- medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
- workers' compensation coverage; or
- any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- 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 you recover from a third party.
- 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, or pay any of your associated costs, including attorneys' fees. 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 shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and reimbursement, including:
    - complying with the terms of this section;
    - providing any relevant information requested;
    - signing and/or delivering documents at its request;
    - 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;
    - responding to requests for information about any accident or injuries;
    - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
    - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- if you receive payment as part of a settlement or judgment from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to it, you agree to hold those settlement 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.

- 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 may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- 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.
- in 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.
- your failure to cooperate with the Plan or its agents 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 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 a third party causes 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 a Covered Person.
- the Plan has the authority to resolve all disputes regarding the interpretation of the language stated herein.

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.

Refund of Overpayments

If LAKE SAINT LOUIS COMMUNITY 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 LAKE SAINT LOUIS COMMUNITY if:

- 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 LAKE SAINT LOUIS COMMUNITY made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The refund equals the amount LAKE SAINT LOUIS COMMUNITY paid in excess of the amount that should have paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help LAKE SAINT LOUIS COMMUNITY 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, LAKE SAINT LOUIS COMMUNITY may reduce the amount of any future Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. LAKE SAINT LOUIS COMMUNITY may have other rights in addition to the right to reduce future Benefits.

SECTION 11 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end.
- 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, the Claims Administrator will still pay claims for Covered Health Care Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for Health Care 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 last day of the month the Claims Administrator receives written notice from LAKE SAINT LOUIS COMMUNITY to end your coverage, or the date requested in the notice, if later.
- The last day of the month your employment with the Company ends, or the last day of the month that the Claims Administrator receives written notice from LAKE SAINT LOUIS COMMUNITY that your employment ended.
- The date the Plan ends.
- The date you stop making the required contributions.
- The date you are no longer eligible.
- The last day of the month you retire or are pensioned under the Plan.

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

- The last day of the month the Claims Administrator receives written notice from LAKE SAINT LOUIS COMMUNITY to end your coverage, or the date requested in the notice, if later.
- The date your coverage ends.
- The date you stop making the required contributions.
- The date your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide at least thirty days' 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, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

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

Coverage for a Disabled Dependent Child

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

- Is not able to be self-supporting because of mental, developmental or physical disability.
- Depends mainly on you for support.

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

The Plan will ask you to furnish proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Plan agrees to this extension of coverage for the child, the Plan may require that a Physician chosen by the Plan examine the child. The Plan will pay for that examination.

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

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

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the *Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*, as defined in Section 15, *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 LAKE SAINT LOUIS COMMUNITY 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.
- 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
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

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
You become entitled to Medicare	N/A	See table below	See table below
LAKE SAINT LOUIS COMMUNITY files for bankruptcy under Title 11, United States Code.	36 months	36 months	36 months

[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.

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.
- 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 your Employer 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 14, Important Administrative Information: ERISA. 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 Employees 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 Employees 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 an Employee qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Employee must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Employee 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 payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- 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.

Uniformed Services Employment and Reemployment Rights Act

An Employee 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 Employee and the Employee'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, Employees 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 an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

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

Regardless of whether an Employee continues health coverage, if the Employee returns to a position of employment, the Employee's health coverage and that of the Employee's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an Employee or the Employee'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 12 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children.
- Your relationship with the Claims Administrator and LAKE SAINT LOUIS COMMUNITY.
- Relationships with Providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to Providers and you.
- Rebates and other payments.
- Workers' compensation not affected.
- The future of the Plan.
- Plan document.

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 the Claims Administrator and LAKE SAINT LOUIS COMMUNITY

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

- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Care Services, which are more fully described in this SPD.

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

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

Relationship with Providers

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

LAKE SAINT LOUIS COMMUNITY and the Claims Administrator do not provide health care services or supplies, nor do they practice medicine. Instead, LAKE SAINT LOUIS COMMUNITY and the Claims Administrator arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The network's credentialing process utilized by the Claims Administrator or its affiliates confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not LAKE SAINT LOUIS COMMUNITY's

employees nor are they employees of the Claims Administrator. LAKE SAINT LOUIS COMMUNITY and the Claims Administrator are not liable for any act or omission of any provider.

The Claims Administrator 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.

LAKE SAINT LOUIS COMMUNITY is 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;
- The funding of Benefits on a timely basis, 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.

You are responsible for all of the following:

- Choosing your own provider;
- Paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Allowed Amounts;
- Paying, directly to your provider, the cost of any non–Covered Health Service;
- Deciding if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- Deciding with your provider what care you should receive.

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

The relationship between you and LAKE SAINT LOUIS COMMUNITY is that of employer and employee. Dependent or other classification as defined in the SPD.

Interpretation of Benefits

LAKE SAINT LOUIS COMMUNITY and the Claims Administrator have the final authority 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.

LAKE SAINT LOUIS COMMUNITY and the Claims Administrator may assign this 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, LAKE SAINT LOUIS COMMUNITY may, in its authority, offer Benefits for services that would otherwise not be Covered Health Care Services. The fact that LAKE SAINT LOUIS COMMUNITY does so in any particular case shall not in any way be deemed to require LAKE SAINT LOUIS COMMUNITY to do so in other similar cases.

Information and Records

LAKE SAINT LOUIS COMMUNITY and the Claims Administrator 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. LAKE SAINT LOUIS COMMUNITY and the Claims Administrator may request additional information from you to decide your claim for Benefits. LAKE SAINT LOUIS COMMUNITY and the Claims Administrator will keep this information confidential. LAKE SAINT LOUIS COMMUNITY and the Claims Administrator 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 LAKE SAINT LOUIS COMMUNITY and the Claims Administrator with all information or copies of records relating to the services provided to you. LAKE SAINT LOUIS COMMUNITY and Claims Administrator 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 Employee's enrollment form. LAKE SAINT LOUIS COMMUNITY and the Claims Administrator agree that such information and records will be considered confidential.

LAKE SAINT LOUIS COMMUNITY and the Claims Administrator 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 LAKE SAINT LOUIS COMMUNITY is required to do by law or regulation. During and after the term of the Plan, LAKE SAINT LOUIS COMMUNITY and the Claims Administrator 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 LAKE SAINT LOUIS COMMUNITY 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 the Claims Administrator, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

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

Incentives to Providers

Network providers may be provided financial incentives by the Claims Administrator or its affiliates 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.
- A practice called capitation which is when a group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain Health Care Services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. Your Co-payment and/or Co-insurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Co-payment and/or Co-insurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Co-payment and/or Co-insurance as described in your Schedule of Benefits.

  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, certain disease management programs, surveys, discount programs, and/or programs to seek care in more cost effective setting and/or from designated Providers. In some instances these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to take part in a program is

yours alone but LAKE SAINT LOUIS COMMUNITY 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.

Hospital and Medical Bill Audit Benefit

This benefit provides you with a cash incentive for discovering and reporting to the Claims Administrator overcharges made on your hospital or other medical bills. The benefit works as follows:

- For purposes of this benefit, only overcharges made for covered services are considered. Charges for telephone, television, newspaper, etc. are not included.
- You must send the Claims Administrator a copy of the itemized bill and indicate on it by circling the overcharge items. The Claims Administrator will review the overcharges with the hospital or other provider.
- If the hospital or provider agrees to reduce its billing by the overcharges, the Plan will pay direct to you 50% of the savings up to a $1,000 benefit per calendar year. No payment will be made if the total overcharges on a bill are less than $10.

Rebates and Other Payments

LAKE SAINT LOUIS COMMUNITY and the Claims Administrator 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. LAKE SAINT LOUIS COMMUNITY and the Claims Administrator may pass these rebates on to you. When rebates are passed on to you they may be taken into account in determining your 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 LAKE SAINT LOUIS COMMUNITY 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.

LAKE SAINT LOUIS COMMUNITY'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 Employee Retirement Income Security Act of 1974 (ERISA), 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 LAKE SAINT LOUIS COMMUNITY 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 Company 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 Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) is the official plan document that has been adopted by the Company. There is no other document that controls the benefits under the Plan.

SECTION 13 - Prescription Drug

What this section includes:

- Coverage policies and guidelines
- Identification card (ID Card) – Network Pharmacy
- When Does the Claims Administrator Limit Selection of Pharmacies?
- Benefits for prescription drug products
- What Happens When a Brand name Drug Becomes Available as a Generic?
- How Do Supply Limits Apply?
- Special Programs
- Prior Authorization Requirements
- Specialty Prescription Drug Products
- Does Step Therapy Apply?
- Rebates and other payments
- Coupons, Incentives and Other Communications
- Exclusions

Coverage Policies and Guidelines

The Claims Administrator's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Claims Administrator's behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include, review of the place in therapy, or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if supply limits or notification requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions than others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat.

The Claims Administrator may from time to time change the placement of a Prescription Drug Product among the tiers. These changes generally will happen twice a year, but no more than six times per Calendar Year. These changes may happen without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for you is a determination that is made by you and your prescribing Physician.

Note: The tier placement of a Prescription Drug Product may change from time to time based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please contact the Claims Administrator at www.myallsaversconnect.com or the telephone number on your ID card for the most up-to-date tier placement.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you do not show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may pay more if you did not verify your eligibility when the Prescription Drug Product was dispensed or when you utilize an out-of-network pharmacy. You may be required to submit your claim to the pharmacy address on the back of your ID card. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Co-payment or Co-insurance. You will receive a 15-day supply of their Specialty Prescription Drug Product to find out if you will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact you each time prior to dispensing the 15-day supply to

confirm if you are tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, by contacting the Claims Administrator at www.myallsaversconnect.com or the telephone number on your ID card.

When Do Does the Claims Administrator Limit Selection of Pharmacies?

If the Claims Administrator determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your choice of Network Pharmacies may be limited. If this happens, the Claims Administrator may require you to choose one Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the chosen Network Pharmacy. If you don't make a choice within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will choose a single Network Pharmacy for you.

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a Network Pharmacy or an Out-of-Network Pharmacy and are subject to Copayments, Annual Deductibles, and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the Section 4, Schedule of Benefits for applicable Copayments, Annual Deductible, and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

Prescription Drugs from a Retail Network or Out-of-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network or Out-of-Network Pharmacy.

Refer to Section 4, Schedule of Benefits for details on retail Network or Out-of-Network Pharmacy supply limits.

Prescription Drug Products from a Mail Order Network or Out-of-Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network or Out-of-Network Pharmacy.

Refer to the Section 4, Schedule of Benefits for details on mail order Network or Out-of-Network Pharmacy supply limits.

Please access the Claims Administrator's website through www.myallsaversconnect.com or call the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Copayment, Annual Deductible, and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-Name Prescription Drug Product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the Benefit Information section. For a single Copayment and/or Coinsurance, after deductible if applicable, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that have been developed. Supply limits are subject from time to time to the Claims Administrator's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Claims Administrator at www.myallsaversconnect.com or the telephone number on your ID card.

Special Programs

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

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization. The reason for obtaining prior authorization is to determine if the Prescription Drug Product is eligible for coverage. Medical Necessity goes beyond drug and diagnosis and takes into consideration the clinical appropriateness of a medication in terms of condition being treated, severity of conditions, type of medication, frequency of use, and duration of therapy. You may determine whether a Prescription Drug Product requires prior authorization by contacting the Claims Administrator at www.myallsaversconnect.com or the telephone number on your ID card.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products. If you require Specialty Prescription Drug Products, the Claims Administrator may direct you to a Designated Pharmacy with whom the Claims Administrator has an arrangement to provide those Specialty Prescription Drug Products. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, the Prescription Drug Product is not eligible for benefits.

Does Step Therapy Apply?

In order to receive benefits for a Prescription Drug Product subject to step therapy requirements, the Claims Administrator may require that your doctor first prescribe another Prescription Drug Product proven to be effective for treatment of your condition. You may determine whether a particular Prescription Drug Product or pharmaceutical product is subject to step therapy requirements by calling the phone number on your identification card.

Rebates and Other Payments

The Claims Administrator may receive rebates for certain drugs included on the Prescription Drug List. As determined by the Claims Administrator, the Claims Administrator may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Deductible, Co-payment and/or Co-insurance.

The Claims Administrator, and a number of the Claims Administrator's affiliated entities, conduct business with pharmaceutical manufacturers. 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 Benefit. the Claims Administrator is not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, the Claims Administrator may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, as you determine, to purchase the described product at a discount. Pharmaceutical manufacturers or an affiliate may pay for and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Exclusions

Exclusions from coverage listed in the Summary Plan Description apply also to this section. The following will not be considered Covered Health Care Services, and Benefits will not be available under this section for the following:

- Prescription Drug Products obtained from an Out-of-Network Pharmacy;
- Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
- Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment;
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay;

- Experimental or Investigational Services or Unproven Services and medications; medications used for experimental treatments for specific disease and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven. This exclusion does not apply to Prescription Drug Products that have been approved by the U.S. Food and Drug Administration (FDA), but have not been approved by the FDA to be lawfully marketed for the proposed use, if the Prescription Drug Product has been recognized as safe and effective for treatment of a particular indication in one or more of the publications or literature listed below:

    - The AMA Drug Evaluations, a publication of the American Medical Association;

    - The AHFS (American Hospital Formulary Service) Drug Information, a publication of the American Society of Health System Pharmacists;

    - Drug Information for the Health Care Provider, a publication of the United States Pharmacopoeia Convention; or

    - medical literature may be accepted in place of the above compendia if all of the following apply:

        - two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed;

        - no article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed; and

        - each article meets the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or is published in a journal specified by the United States Department of Health and Human Services as accepted peer-reviewed medical literature;

- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law;

- Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

- Any product dispensed for the purpose of appetite suppression or weight loss;

- A Pharmaceutical Product for which Benefits are provided in your Summary Plan Description;

- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies. This exclusion does not apply to diabetic supplies and inhaler spacers specifically stated as covered;

- General vitamins, except the following which require a Prescription Order or Refill:

    - Prenatal vitamins
    - Vitamins with fluoride
    - Single entity vitamins

- Unit dose packaging of Prescription Drug Products;

- Medications used for cosmetic purposes;

- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Claims Administrator determines do not meet the definition of a Covered Health Care Service;

- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed;

- Prescription Drug Products when prescribed to treat infertility;

- Treatment for toenail onychomycosis (toenail fungus);

- Certain prescription Drug Products for tobacco cessation;

- Diagnostic kits and products;
- Dental products, including but not limited to prescription fluoride topicals;
- Prescription Drug Products not placed on Tier-1, Tier-2, Tier-3, or Tier-4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed;
- Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider;
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products 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 Product that was previously excluded under this provision;
- New Prescription Drug Products and/or new dosage forms until the date they are placed on a tier by the Claims Administrator's Prescription Drug List Management Committee;
- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill;
- Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury;
- A Prescription Drug Product that contains marijuana, including medical marijuana;
- New Pharmaceutical Products and/or new dosage forms until the date they are reviewed by the Claims Administrator.
- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product;
- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product;
- A Prescription Drug Product with either:

  An approved biosimilar

  A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product

  For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

  It is highly similar to a reference product (a biological Prescription Drug Product)

  It has no clinically meaningful differences in terms of safety and effectiveness from the reference product

  Such determinations may be made up to six times per calendar year.
- Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

SECTION 14 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by *ERISA* as defined in Section 15, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

LAKE SAINT LOUIS COMMUNITY is the Plan Sponsor and Plan Administrator of the LAKE SAINT LOUIS COMMUNITY Welfare Benefit Plan and has the authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator - Medical Plan

LAKE SAINT LOUIS COMMUNITY
100 COGNAC CT
LAKE SAINT LOUIS, MO 63367-1624
(636) 625-8276

Claims Administrator

United HealthCare Services, Inc., or its affiliates or designee is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative services agreement with the LAKE SAINT LOUIS COMMUNITY. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
PO Box 19032
Green Bay, WI 54307-9032

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - Medical Plan

LAKE SAINT LOUIS COMMUNITY
100 COGNAC CT
LAKE SAINT LOUIS, MO 63367-1624
(636) 625-8276

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by *ERISA*.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	LAKE SAINT LOUIS COMMUNITY Health Benefit Plan
Plan Number:	501
Employer ID:	430918352
Plan Type:	Welfare benefits plan
Plan Year:	September 01 - August 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under *ERISA*. *ERISA* provides that all Plan participants shall be permitted to:

- Receive information about Plan Benefits.
- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents - including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the address provided in Section 8, *Questions, Complaints and Appeals*.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, *ERISA* imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under *ERISA*.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 8, *Questions, Complaints and Appeals*, for details.

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor*, listed in your telephone directory, or write to the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

The Plan's Benefits are administered by LAKE SAINT LOUIS COMMUNITY, the Plan Administrator. The Claims Administrator, United Healthcare Services Inc. or its affiliate or designee is the Claims Administrator and processes claims for the Plan and provides appeal services; however, the Claims Administrator and LAKE SAINT LOUIS COMMUNITY are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or Out-of-Network provider. The Claims Administrator and LAKE SAINT LOUIS COMMUNITY are neither liable nor responsible for the treatment, services or supplies provided by Network or Out-of-Network providers.

SECTION 15 - GLOSSARY

What this sections includes:

- Definitions of terms used throughout the 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.

Definitions

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.

Allowable Expense - any necessary, regular, and customary expense, all or part of which is covered by at least one of the plans covering the Covered Person. Allowable Expenses to a Secondary Plan include the value or amount of any deductible amount or coinsurance percentage or amount of otherwise allowable expenses which is not paid by the Primary (first paying) Plan.

Some plans provide benefits in the form of services rather than cash payments. For those plans, the reasonable cash value of such service rendered is deemed to be both an Allowable Expenses and a benefit paid.

Allowed Amount – for Covered Health Care Services, incurred while the Plan is in effect, Allowed Amounts are determined by the Claims Administrator as stated below.

Allowed Amounts are the amount the Claims Administrator determines that the plan will pay for Benefits. For Network Benefits, for Covered Health Care Services provided by a Network provider except for cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills. For Out-of-Network Benefits, you are responsible for paying, directly to the out-of-Network provider, any difference between the amount the provider bills you and the amount the plan will pay. Allowed Amounts are determined solely in agreement with the Claims Administrator's reimbursement policy guidelines, as described in this *Summary Plan Description.*

For Network Benefits, Allowed Amounts are based on either of the following:

When Covered Health Care Services are received from a Network provider, Allowed Amounts are the Claims Administrator's contracted fee(s) with that provider.

For Out-of-Network Benefits, Allowed Amounts are based on either of the following:

When Covered Health Care Services are received from an Out-of-Network provider, Allowed Amounts are determined, based on:

- Negotiated rates agreed to by the Out-of-Network provider and either the Claim's Administrator or one of their vendors, affiliates or subcontractors.
- If rates have not been negotiated, then one of the following amounts:
  - Allowed Amounts 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 with the exception of the following.
    - 50% of *CMS* for the same or similar laboratory service.
    - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
  - When a rate is not published by *CMS* for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows:
    - For services other than Pharmaceutical Products, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s)

currently in use become no longer available, the Claims Administrator will use a comparable scale(s). The Claims Administrator and *OptumInsight* are related companies through common ownership by UnitedHealth Group.

- For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale prices for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

- When a rate for a laboratory service is not published by CMS for the service and gap methodology does not apply to the service, the rate is based on the average amount negotiated with similar Network providers for the same or similar service.

- When a rate for all other services is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 50% of the provider's billed charge.

- For Mental Health Care and Substance-Related and Addictive Disorders Services the Allowed Amount will be reduced by 25% for Covered Health Care Services provided by a psychologist and by 35% for Covered Health Care Services provided by a master's level counselor.

The Claims Administrator updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically put in place within 30 to 90 days after *CMS* updates its data.

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

For Covered Health Care Services received at a Network facility on a non-Emergency basis from an out-of-Network facility based Physician, the Allowed Amount is based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market with the exception of the following

- 50% of *CMS* for the same or similar laboratory service.

- 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.

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 or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claim Administrator will use a comparable scale(s). The Claims Administrator and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*.

For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 50% of the provider's billed charge.

For Mental Health Care and Substance-Related and Addictive Disorders Services the Allowed Amounts will be reduced by 25% for Covered Health Care Services provided by a psychologist and 35% for Covered Health Care Services provided by a masters level counselor.

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

For Emergency Health Care Services provided by an out-of-Network Provider, the Allowed Amount is a rate agreed upon by the out-of-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.

- 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.

- The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the same service.

When a rate is not published by CMS or data resources of competitive fees in a geographic area are not available 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 or similar methodology. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claim Administrator will use a comparable scale(s). The Claims Administrator and OptumInsight are related companies through common ownership by UnitedHealth Group.

For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or UnitedHealthcare based on an internally developed pharmaceutical pricing resource.

When a rate is not published by CMS for the service and a gap methodology does not apply to the service, the Allowed Amount is based on 50% of the provider's billed charge

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

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 Care Services; or

- Rehabilitative, laboratory, diagnostic or therapeutic services.

Amendment - any attached written description of added or changed 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.

Ancillary Charge - a charge, in addition to the Deductible, Co-payment and/or Co-insurance, that you must pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available.

For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product.

- The Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product.

Annual Deductible - The amount you must pay for Covered Health Care Services per calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 4, Schedule of Benefits.

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

Benefits - Plan payments for Covered Health Care Services subject to the terms, conditions, limitations, exclusions and eligibility requirements of the Plan and any Addendums and/or Amendments.

Brand-name - a Prescription Drug Product:

- which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or

- that the Claims Administrator identifies as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors.

You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Calendar Year - January 1 through December 31.

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

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Chiropractic Treatment (adjustments) – a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Claim Determination Period - a period of time during which you are covered by the plan.

Claims Administrator - United HealthCare Services, Inc. and its affiliates or subcontractors, who provide certain claim administration services for the Plan

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

Coinsurance - the percentage of Allowed Amounts you are required to pay for Covered Health Care Services as described in Section 3, How the Plan Works.

Company - LAKE SAINT LOUIS COMMUNITY

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

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

NOTE: For Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Copayment; or
- The Allowed Amount.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

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

- Provided for the purpose of preventing, evaluating, diagnosing or treating of a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or symptoms;
- Incurred while you and your Dependent are covered by the plan;
- Prescribed, ordered, recommended or approved by an authorized health care provider;
- Medically Necessary;
- Not subject to an applicable limitation or exclusion; and
- Allowed under all other applicable terms and conditions of the *Plan*.

The Plan does not pay for that part of a Covered Health Care Service which:

- Is subject to a Copayment, Annual Deductible, Coinsurance or penalty; or
- Exceeds an applicable benefit maximum; or
- Is not an Allowed Amount.

Covered Person - either the Participant or an Enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating);
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for more independent existence.

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

Dependent - the Participant's legal Spouse or a child of the Participant or the Participant's Spouse. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.The term child includes any of the following:

- A natural child;
- A stepchild;
- A legally adopted child;
- A child placed for adoption; and
- A child for whom legal guardianship has been awarded to the Participant or the Participant's Spouse.

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

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under age 26;
- A child is no longer eligible as a Dependent when the child reaches age 26 except as provided in Section 11: *When Coverage Ends* under *Coverage for a Disabled Dependent Child*.

The Subscriber must reimburse the Plan for any Benefits paid for a child at a time when the child did not satisfy these conditions.

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. The Plan Administrator is responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

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 Care Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Pharmacy - a pharmacy that has entered into an agreement with the Claims Administrator or the Claims Administrator's pharmacy benefits manager to provide specific prescription drug products. The fact that a pharmacy is a member pharmacy does not mean that it is a Designated Pharmacy.

Domestic Partner - a person of the same or opposite sex with whom the participant has established a Domestic Partnership.

Domestic Partnership - A relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years old;

- They must share the same permanent residence and the common necessities of life.
- They must be mentally competent to enter into a contract.
- They must be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:

  They have a single dedicated relationship of at least 6 months duration.

  They have joint ownership of a residence.

  They have at least two of the following:

  - A joint ownership of an automobile.
  - A joint checking, bank or investment account.
  - A joint credit account.
  - A lease for a residence identifying both partners as tenants.
  - A will and/or life insurance policies which designate the other as primary beneficiary.

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

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

Eligible Person - an Employee of LAKE SAINT LOUIS COMMUNITY or other person whose connection with LAKE SAINT LOUIS COMMUNITY meets the eligibility requirements shown in both the Employers' application and the Plan. An Eligible Person must reside within the United States.

Emergency - a medical condition that manifests itself by sudden symptoms of sufficient severity, (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency. Emergency Health Care Services include:

- a medical screening examination, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency medical condition; and
- such further medical examination and treatment that are required by federal law to stabilize an Emergency medical condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

Employee - a full-time Employee of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. An Employee must live and/or work in the United States.

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

Employer - LAKE SAINT LOUIS COMMUNITY

Enrolled Dependent - a Dependent who is covered under the Plan.

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

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not 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 Experimental or Investigational); or
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial described 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 5, Additional Coverage Details.
- The Claims Administrator may, as it determines, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
    - You are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 1: Covered Health Care Services; and
    - You have a Sickness or condition that is likely to cause death with one year of the request for treatment.

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

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

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

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

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

Generic - a Prescription Drug Product:

- that is Chemically Equivalent to a Brand-name drug; or
- that the Claims Administrator identifies as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand 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.

Hearing Aid - an electronic amplifying device designed to bring sound more effectively into the ear. A Hearing Aid consists of microphone, amplifier and receiver.

Hearing Impairment - a reduction in the ability to perceive sound which may range from slight to complete deafness.

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

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

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

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

Initial Enrollment Period - the first period of time at new business when Eligible Persons may enroll themselves and their Dependents under the Plan. The initial enrollment period ends once the installation process is complete and a policy number is generated for the group

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding 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 certain circumstances when the need for more care is finite and predictable.

Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Plan at a time other than the following:

- during the Initial Enrollment Period;
- during an Open Enrollment Period;
- during a special enrollment period as described in Section 2, *Introduction*; or
- within 31 days of the date a new Eligible Person first becomes eligible.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic 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.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes. This list is subject to the Claims Administrator's periodic review and modification.

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.

Medical Child Support Order - any judgment, decree, or order including approval of a settlement agreement which is made:

- under a state domestic relations law and requires child support or requires health and/or dental coverage for the child; or
- by a state agency under a state law for medical child support that is required under the federal Social Security Act.

The Medical Child Support Order must be issued by a court of competent jurisdiction, or issued through a state administrative process, and has the force and effect of law.

Medical Necessity or Medically Necessary – health care services that are all of the following as determined by the Claims Administrator or their designee:

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

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

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

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting their determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on www.myallsaversconnect.com or by calling Customer Care at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

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

For purposes of this definition, a Mental Health Condition does not include Substance-Related and Addictive Disorders.

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

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. This does not include those providers who have agreed to discount their charges for Covered Health Care Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

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

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The Schedule of Benefits will tell you details about how Network Benefits apply.

Network Pharmacy - a pharmacy that has:

- entered into an agreement with the Claims Administrator or an organization contracting on the Claims Administrator's behalf to provide Prescription Drug Products to Covered Persons;
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products; and
- been designated by the Claims Administrator as a Network Pharmacy.

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

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

Open Enrollment Period - – thirty days prior to the renewal date of the Plan during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by out-of–Network providers. Refer to Section 4, Schedule of Benefits for details about how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you may pay every Calendar Year. The Schedule of Benefits will tell you how the Out-of-Pocket Limit applies.

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

Participant - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Pharmaceutical Product(s) - FDA-approved prescription medication or products administered in connection with a Covered Health Care Service by a Physician.

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

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

Plan - the LAKE SAINT LOUIS COMMUNITY Medical Plan

Plan Administrator - LAKE SAINT LOUIS COMMUNITY or its designee.

Plan Sponsor - LAKE SAINT LOUIS COMMUNITY.

Predominant Reimbursement Rate - the charges incurred for a Prescription Drug Product not dispensed at a member pharmacy that will be considered covered expenses under the Plan. The Predominant Reimbursement Rate for a particular Prescription Drug Product includes the dispensing fee and sales tax. The Predominant Reimbursement Rate will be set at the Prescription Drug Product cost that the Claims Administrator's pharmaceutical benefits manager and most member pharmacies have agreed to for that Prescription Drug Product.

Prescription Drug Cost - the rate the Claims Administrator has agreed to pay the Claims Administrator's Network Pharmacies, including a dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications or products that have been approved by the U.S. Food and Drug Administration. This list is subject to the Claims Administrator's periodic review and modification (generally twice a year, but no more than six times per Calendar Year). You may determine to which tier a particular Prescription Drug Product has been assigned through www.myallsaversconnect.com or by calling Customer Service at the telephone number on your ID card.

Prescription Drug List Management Committee - the committee that the Claims Administrator designates for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers);
- Insulin;
- Certain immunizations administered in a pharmacy.
- The following diabetic supplies:
  - standard insulin syringes with needles;
  - blood-testing strips - glucose;
  - urine-testing strips - glucose;
  - ketone-testing strips and tablets;
  - lancets and lancet devices; and
  - glucose meters. This does not include continuous glucose monitors. Benefits for continuous glucose monitors are provided as described in Section 5. Additional Coverage Details.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

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

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 Cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication by calling Customer Care at the telephone number on your ID card.

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

Primary Plan - the plan which determines its benefits before those of the other Plan and without considering the other Plan's benefits.

Qualified - the Medical Child Support Order:

- creates or recognizes the child's right to receive health and/or dental coverage;
- includes the required name and last known mailing address of the child and a reasonable description of the coverage to be provided;
- includes the time period to which the Medical Child Support Order applies; and
- does not require a type of coverage not otherwise provided by the plan, except as necessary under applicable law.

Residential Treatment Facility - a facility established and operated as required by law which provides Mental Health Care Services or Substance Related and Addictive Disorder Services. It must meet all of the following requirements:

- Provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and full- time participation.
- Provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Secondary Plan - the plan which determines its benefits after those of the other Plan. The benefits of the Secondary Plan may be reduced because of the other Plan's benefits.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi–private Room is a Covered Health Care Service, the difference in cost between a Semi–private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi–private Room is not available.

Shared Savings Program - a program in which the Claims Administrator may obtain a discount to an out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-Network provider. When this happens, you may experience lower out-of-pocket amounts. Co-insurance and any applicable deductible would still apply to the reduced charge. Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by the Claims Administrator. This means, when contractually permitted, the plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider In this case, the out-of-Network provider may bill you for the difference between the billed amount and the rate determined by the Claims Administrator. If this happens, you should call the telephone number shown on your ID card. Shared Savings Program providers are not Network providers and are not credentialed by the Claims Administrator.

Sickness - disorder, dysfunction, or illness of the body.

Skilled Care – skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.

- Ordered by a Physician.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spouse - an individual to whom you are legally married or a Domestic Partner as defined in this section.

Subscriber - an Eligible Employee who is properly enrolled under the Plan.

Substance Related and Addictive Disorder Services - 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. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person.

Terminally ill - A prognosis, given by a Physician, that a Covered Person has six months or less to live.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Therapeutically Equivalent - when Prescription Drug Products can be expected to produce essentially the same therapeutic outcome and toxicity.

Unproven Service(s) - 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. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

The Claims Administrator has a process by which it compiles and reviews clinical evidence with respect to certain Health Care Services. From time to time, the Claims Administrator 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.

NOTE:

- if you have a life-threatening Sickness or condition (one that is likely to cause death within two years of the request for treatment) the Claims Administrator may, as the Claims Administrator determines, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health;

- the Claims Administrator may, as the Claims Administrator determines, consider an otherwise Unproven Service to be a Covered Health Care Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to happen, all of the following conditions must be met:

- if the service is one that requires review by the U.S. Food and Drug Administration (FDA), it must be FDA-approved;
- it must be performed by a Physician and in a facility with demonstrated experience and expertise;
- the Covered Person must consent to the procedure acknowledging that the Claims Administrator does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective;
- at least two studies must be available in published peer-reviewed medical literature that would allow the Claims Administrator to conclude that the service is promising but unproven; and
- the service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Care Service is solely at the authority of the Claims Administrator. Other apparently similar promising but Unproven Services may not qualify.

Urgent Care Center - a facility that provides Covered Health Care Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Health Care Reform Notice

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.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer

ADDENDUM – Real Appeal

This Addendum to the Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Real Appeal

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but is not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.

- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.

- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, please access allsavers.realappeal.com or contact the number shown on your ID card.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at www.myallsavers.com or by calling 1-800-291-2634. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-291-2634 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$3,000 / Individual Network $6,000 / Family Network $6,000 / Individual Out-of-Network $12,000 / Family Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $5,500 individual / $11,000 family; For out-of-network providers $11,000 individual / $22,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.myallsavers.com or call 1-800-291-2634 for a list of Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit deductible does not apply	50% coinsurance	None
	Specialist visit	$60 copay/visit deductible does not apply	50% coinsurance	
	Preventive care/screening/ immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Physician: 0% coinsurance Facility: 0% coinsurance	Physician: 50% coinsurance Facility: 50% coinsurance	Sleep studies require a Prior Authorization or benefits could be reduced by 50% of the total cost of the service.
	Imaging (CT/PET scans, MRIs)	Physician: 0% coinsurance Facility: 0% coinsurance	Physician: 50% coinsurance Facility: 50% coinsurance	Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If you need drugs to treat your illness or condition	Tier 1 drugs	$15 retail copay/prescription deductible does not apply or $38 mail-order copay/ prescription deductible does not apply.	$15 retail copay/prescription deductible does not apply or $38 mail-order copay/ prescription deductible does not apply.	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail prescription). If a dispensed drug has a chemically equivalent drug at a lower tier, the cost difference between drugs in addition to
	Tier 2 drugs	$35 retail copay/prescription deductible does not apply or $88 mail-order copay/ prescription deductible does not apply.	$35 retail copay/prescription deductible does not apply or $88 mail-order copay/ prescription deductible does not apply.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at www.myallsavers.com	Tier 3 drugs	$75 retail copay/prescription deductible does not apply or $188 mail-order copay/ prescription deductible does not apply.	$75 retail copay/prescription deductible does not apply or $188 mail-order copay/ prescription deductible does not apply.	any applicable copay and/or coinsurance may be applied. Certain drugs may have a prior authorization requirement. If you use an out-of-network pharmacy (including a mail order pharmacy), you may be responsible for any amount over the allowed amount.
	Tier 4 drugs	$250 retail copay/prescription deductible does not apply or $625 mail-order copay/ prescription deductible does not apply.	$250 retail copay/prescription deductible does not apply or $625 mail-order copay/ prescription deductible does not apply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: $60 copay/visit deductible does not apply Surgeon: 0% coinsurance	Physician: 50% coinsurance Surgeon: 50% coinsurance	
If you need immediate medical attention	Emergency room services	Physician: 0% coinsurance Facility: $300 copay/0% coinsurance	Physician: 0% coinsurance* Facility: $300 copay/0% coinsurance*	*Out-of-Network emergency services are covered at the network benefit level.
	Emergency medical transportation	0% coinsurance	0% coinsurance*	
	Urgent care	Physician: $100 copay/visit deductible does not apply Facility: $100 copay/visit deductible does not apply	Physician: 50% coinsurance Facility: 50% coinsurance	One copay is applied per network urgent care visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Physician/surgeon fees	Physician: $60 copay/visit deductible does not apply Surgeon: 0% coinsurance	Physician: 50% coinsurance Surgeon: 50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health or substance abuse services.	Outpatient services	Physician: $60 copay/visit deductible does not apply Facility: 0% coinsurance for other outpatient services	Physician: 50% coinsurance Facility: 50% coinsurance	None
	Inpatient services	Physician: $60 copay/visit deductible does not apply Facility: 0% coinsurance	Physician: 50% coinsurance Facility: 50% coinsurance	Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If you are pregnant	Office visits	$30 copay/visit deductible does not apply	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prior Authorization is required for inpatient services. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	
	Home health care	0% coinsurance	50% coinsurance	30 visits/year. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If you need help recovering or have other special health needs	Rehabilitation services	0% coinsurance	50% coinsurance	30 combined visits/year for rehabilitation and habilitation services. Includes physical therapy, speech therapy, occupational therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy.
	Habilitation services	0% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	0% coinsurance	50% coinsurance	60 visits/year. Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Durable medical equipment	0% coinsurance	50% coinsurance	Prior Authorization is required if greater than $1000. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
	Hospice service	0% coinsurance	50% coinsurance	Prior Authorization is required. If you don't get Prior Authorization, benefits could be reduced by 50% of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the United States
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care, and
- Weight-loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Hearing aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa. Other options to continue coverage are available to you too, including individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: All Savers at 1-800-291-2634, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-291-2634.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-291-2634.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-291-2634.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-291-2634.

_____ *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* _____

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** $3,000
- **Specialist copayment** $60
- **Hospital (facility) coinsurance** 100%
- **Other coinsurance** 100%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	$3,110

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible:** $3,000
- **Specialist copayment** $60
- **Hospital (facility) coinsurance** 100%
- **Other coinsurance** 100%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay

Cost Sharing	
Deductibles	$300
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,720

Mia's Simple fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible:** $3,000
- **Specialist copayment** $60
- **Hospital (facility) coinsurance** 100%
- **Other coinsurance** 100%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$1,900**

In this example, Mia would pay

Cost Sharing	
Deductibles	$1,400
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,800

The **plan** would be responsible for the other costs of these EXAMPLE covered services

All Savers®
Alternate Funding

Federal Women's Health and Cancer Rights Act of 1998

The Federal Women's Health and Cancer Rights Act of 1998 requires that benefits must be provided for:

- Reconstruction of a surgically removed breast;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications from all stages of mastectomy, including lymphedemas.

These benefits are subject to applicable terms and conditions under your health plan, including copayments, deductible and coinsurance provisions. They are also subject to medical insurance limitations and exclusions.

UnitedHealthcare®

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MEDICAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

We (including our affiliates listed at the end of this notice) are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on our websites, such as www.uhone.com, www.myuhone.com, www.uhone4me.com, www.myallsavers.com, or www.myallsaversconnect.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

We collect and maintain oral, written and electronic information to administer our business and to provide products, services and information of importance to our customers. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and Federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage and to process claims for health care services you receive including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment**. We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations**. We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services.
- **To Plan Sponsors**. If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with Federal law.
- **For Underwriting Purposes**. We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders**. We may use or disclose health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person or report a crime.

33638-X-201902 Products are either underwritten or administered by: All Savers Insurance Company, All Savers Life Insurance Company of California, Golden Rule Insurance Company, Oxford Health Insurance, Inc., UnitedHealthcare Insurance Company, and/or UnitedHealthcare Life Insurance Company.

- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** including disclosures required by state workers' compensation laws that govern job-related injury or illness.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets Federal privacy law requirements.
- **To Provide Information Regarding Decedents**. We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes**. We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and pursuant to Federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by Federal law.
- **Additional Restrictions on Use and Disclosure.** Certain Federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. Such laws may protect the following types of information: Alcohol and Substance Abuse, Biometric Information, Child or Adult Abuse or Neglect, including Sexual Assault, Communicable Diseases, Genetic Information, HIV/AIDS, Mental Health, Minors' Information, Prescriptions, Reproductive Health, and Sexually Transmitted Diseases.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by Federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under Federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, call the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept verbal requests to receive confidential communications; however, we may also require you to confirm your request in writing, In addition, any request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have it sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend information** we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which Federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. In addition, you may obtain a copy of this notice at our websites such as www.uhone.com, www.myuhone.com, www.uhone4me.com, www.myallsavers.com, or www.myallsaversconnect.com.
- **You have the right to be considered a protected person**. *(New Mexico only) A "protected person" is a victim of domestic abuse who also is either; (i) an applicant for insurance with us; (ii) a person who is or may be covered by our insurance; or (iii) someone who has a claim for benefits under our insurance.*

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, please call the toll-free phone number on your health plan ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed below.
- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, requesting

copies of your records, or requesting amendments to your record at the following address:

- Privacy Office, 7440 Woodland Drive, Indianapolis, IN 46278-1719
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

Fair Credit Reporting Act Notice

In some cases, we may ask a consumer-reporting agency to compile a consumer report, including potentially an investigative consumer report, about you. If we request an investigative consumer report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the Federal Fair Credit Reporting Act.

We may disclose information solely about our transactions or experiences with you to our affiliates.

MIB

In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a not-for-profit organization of life and health insurance companies that operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., 50 Braintree Hill Park Ste. 400, Braintree, MA 02184-8734, 1-866-692-6901*, www.mib.com*.

FINANCIAL INFORMATION PRIVACY NOTICE (Effective January 1, 2019)

We (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an insured or an applicant for coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

We restrict access to personal financial information about you to employees, affiliates and service providers who are involved in administering your health care coverage or providing services to you. We maintain physical, electronic and procedural safeguards that comply with Federal standards to guard your personal financial information.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and Federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions About this Notice

If you have any questions about this notice, you may contact a UnitedHealthOne Customer Call Center Representative. For Golden Rule Insurance Company members call us at 1-800-657-8205 (TTY 711). For All Savers Insurance Company members, call us at 1-800-291-2634 (TTY 711).

The Financial Information Privacy Notice, effective January 1, 2019, is provided on behalf of: All Savers Insurance Company; All Savers Life Insurance Company of California; Golden Rule Insurance Company; Oxford Health Insurance, Inc.; UnitedHealthcare Insurance Company; and UnitedHealthcare Life Insurance Company.

To obtain an authorization to release your personal information to another party, please go to the appropriate website listed in this Notice.

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