

Summary Plan Description

The Curators of the University of Missouri Healthy Savings Plan (a Choice Plus Network)

Effective: January 1, 2025
Group Number: 905610



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 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
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 - Qualified interpreters
 - Information written in other languages

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Carol Wilson, Director, Health & Benefits
1105 Carrie Francke Drive, Suite 108, Columbia, MO 65211
Phone: 573-882-2406
Fax: 573-882-9155
wilsoncaro@umsystem.edu

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U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

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- **ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-634-1237.
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- **توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-634-1237 تماس بگیرید.
- **XIYYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-634-1237.
- **ATENÇÃO:** Se fal a português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-634-1237.
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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/ Substance-Related and Addictive Disorder Administrator: 1-844-634-1237.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30884, Salt Lake City, UT 84130.
- Online assistance: www.myuhc.com.

The Curators of the University of Missouri (the University) sponsors this Plan (which includes the Prescription Drug Plan described in the section titled "Express Scripts Prescription Drug Plan") for the benefit of its Employees and their Dependents.

This Summary Plan Description (SPD) describes the health Benefits available to you and your covered family members under the Plan as of January 1, 2021. **This SPD serves as both the Plan document and the SPD.** It includes summaries of:

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

This SPD is designed to meet your information needs. It supersedes any previous printed or electronic SPD for this Plan. It is important that you carefully review this SPD to understand the Benefits which are available, as well as your responsibilities to ensure that you receive all the Benefits to which you are eligible. If a service or procedure is not specifically referenced in the SPD, coverage will be in accordance with UnitedHealthcare standard policies or determined at the discretion of the Employer. The terms of this Plan may not be amended by oral statements made by the Plan Sponsor, the Administrative Committee, the Claims Administrator, or any other person. In the event an oral statement conflicts with any term of the Plan, the Plan terms will control.

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 13, *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 mean that the procedure or treatment is a Covered Health Service under the Plan.

Please Note

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

IMPORTANT

The University intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice subject to any collective bargaining agreements between the Employer and various unions, if applicable.

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 SPD and any other written document, your rights shall be determined under this SPD.

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

If you have questions there is a number you can call on the back of your ID card to talk with a United Healthcare member services representative.

How To Use This SPD

- Read the entire SPD thoroughly to learn how the Plan works and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- Copies of this SPD and any future Amendments are located on the UM System Office of Human Resources website (<http://umurl.us/TR>) or you can request printed copies by contacting the HR Service Center or your HR Generalist
- Capitalized words in the SPD have special meanings and are defined in Section 13, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 13, *Glossary*.
- The Curators of the University of Missouri is also referred to as "the University."
- The term "written application" includes electronic forms.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications), any summary of benefit coverage (SBC), or other written information provided to you, this SPD will control.
- When there is a reference to "the Plan" in this SPD, it is referring to the Healthy Savings Plan (a Choice Plus Network).

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 an **Employee** of the University and Actively at Work.

Employee means:

- a person with a fully benefit eligible academic appointment, meaning an employee on "academic staff appointment" (as defined in University Collected Rules and Regulations (CRR) 310.020), who is expected to work at least 75% full-time equivalence and has an indicated appointment duration of at least nine (9) months; or
 - For the purpose of the preceding paragraph, any individual who is simultaneously employed by the University and the Harry S. Truman Veterans Administration Hospital pursuant to an agreement between said organizations, and whose joint appointments, combined, otherwise meet the requirements of the preceding paragraph, shall be considered an Employee.
- an administrative, service and support employee classified as a "regular employee" (as defined in CRR 320.050), meaning an administrative, service and support employee who is expected to work at least 75% full-time equivalence and has an indicated appointment duration of at least nine (9) months; or
- A variable-hour, seasonal or part-time employee who has been determined to have worked thirty (30) hours or more on average per week during the University's designated "measurement period" (as defined in Section 4980H of the Code and the regulations issued thereunder, for UM measurement periods refer to <http://umurl.us/PPACA>). A variable-hour employee includes:
 - an employee on "academic staff appointment" (as defined in CRR 310.020) whose appointment does not qualify for fully benefit eligible academic appointment status, described above; or
 - an administrative, service and support employee who is either: (a) a "nonregular employee" (as defined in CRR 320.050), meaning an individual whose appointment does not qualify for "regular employee" status (as defined in CRR 320.050), or (b) a "per diem employee" (as defined in CRR 320.050), meaning an individual whose appointment is not a part of an operating unit's regular work schedule, who is scheduled to work only on an

"as needed" basis, and who is provided an hourly rate of pay following approved rate schedule(s); or

- a student employee, meaning an individual enrolled as a student at the University whose primary association with the University is related to the pursuit of an academic program; or
- a "subsidiary employee" (as defined in CRR 320.050) who:
 - is expected to work at least 75% percent full-time equivalence and has an indicated appointment duration of at least nine months if classified as a "regular employee;" or
 - has been determined to have worked thirty (30) hours or more on average per week during the "subsidiary entity's" (as defined in CRR 320.050) designated "measurement period" if classified as a variable hour, seasonal, or part-time employee.

All service with the Employer or a "subsidiary entity" (as defined in CRR 320.050) is counted when determining how much an employee is expected to work or has worked during the University's or the "subsidiary entity's" designated "measurement period."

The term Employee does not include independent contractors, Retired Employees, or individuals who meet the definition of total disability under the University's Long Term Disability Plan and do not meet the End-Stage Renal Disease requirements, below.

You are also eligible to enroll in the Plan if you are totally disabled (as that term is defined in the University's Long Term Disability Plan) and the following conditions are satisfied:

- immediately prior to becoming totally disabled (as the term is defined in the University's Long Term Disability Plan), you were an Employee, as described above;
- you are entitled to continued service credit (ie. vested) as a disabled Employee under the University's Retirement, Disability and Death Benefit Plan;
- you are eligible for Medicare solely due to End-Stage Renal Disease (regardless of whether or not you actually enroll in Medicare);
- your eligibility for Medicare occurred prior to when you met the definition of total disability under the University's Long Term Disability Plan; and
- less than thirty-one (31) months have elapsed from the date you first became eligible for Medicare because of End-Stage Renal Disease.

Your eligible **Dependents** may also participate in the Plan. Dependent means:

- the Spouse of an Employee;
- each Child of an Employee through the end of the month such Child reaches 26 years of age. See *Section 13- Glossary, subsection Child or Children*, for a definition;
 - Legal guardianship ends on the child's 18th birthday, unless there is a court order extending the guardianship.

- Each unmarried Child of an Employee who is mentally or physically incapable of self-sustaining employment prior to reaching the maximum age and who is dependent on you or your Spouse for Principal Financial Support. See *Section 11-When Coverage Ends, subsection Coverage for a Disabled Dependent Child* for more information.
 - This definition shall be effective January 1, 1994 and shall not be construed to eliminate the eligibility of any Dependent covered by the Plan as of December 31, 1993.
- the Sponsored Adult Dependent of an Employee, so long as the Employee does not have a Spouse.
- a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 12, *Other Important Information*.

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

Your Dependents may not enroll in the Plan unless you are also enrolled. Under no circumstances may any person be enrolled in the plan under more than one participant.

- If you are eligible for Coverage based on your employment with the University you may be Covered under your own employment or you may be Covered as a Dependent, but not both.
- If you and your Spouse or Sponsored Adult Dependent are both covered under the Plan, only one parent may enroll your Child as a Dependent.
- If you are eligible for Coverage as both a Spouse or Sponsored Adult Dependent and a Child, only one participant may enroll you in the plan as a Dependent.

IMPORTANT: Documentation is required to enroll a Dependent under this Plan.

When you enroll a Dependent under this Plan, you must provide proof of that Dependent's relationship to you and satisfaction of the Plan's Dependent eligibility requirements. If you are enrolling a Dependent outside of the Annual Enrollment period due to a loss of coverage, you must also provide proof of coverage loss (ie. certificate of creditable coverage or letter from former plan). A Dependent may participate in the Plan only if documentation proving the Dependent's relationship to the Employee and loss of coverage (when applicable) is submitted to the University.

Acceptable documentation is located on the UM System Office of Human Resources website under forms & guides: <http://umurl.us/proof>.

In the case of Dependents added during Annual Enrollment, documentation must be submitted within thirty-one (31) days of the close of Annual Enrollment or coverage will not be effective on January 1 of the following plan year.

For enrollment occurring outside of Annual Enrollment period (e.g., because of a special enrollment right or a family/employment status change), all required documentation must be submitted to the University within thirty-one (31) days of the date you enroll the Dependent in the Plan. Failure to timely provide the required documentation will result in retroactive termination of the Dependent's coverage to the date coverage began.

When you enroll a Dependent in the Plan, you represent the following to be true:

- The individual is eligible under the terms of the Plan; and
- You will provide documentation evidencing eligibility (including proof of loss of coverage, if applicable) within thirty-one (31) days of the date the individual is enrolled in the Plan (or within thirty-one (31) days of the close of Annual Enrollment in the case of Dependents added during Annual Enrollment).

Further, you understand that:

- The Plan is relying on your representation of eligibility in accepting the enrollment of your Dependent(s);
- Your failure to provide the required documentation may be evidence of fraud and material misrepresentation; and
- Your failure to provide the required documentation within thirty-one (31) days of the date the individual is added to the Plan will result in termination of the Dependent's coverage under the Plan **retroactively** to the date coverage began (or, for a Dependent enrolled during Annual Enrollment, will result in no coverage for the Dependent on January 1).

Newborns: Documentation of newborn eligibility must be provided to the University within thirty-one (31) days of enrolling the newborn in the Plan. Coverage for the newborn Dependent will exist as requested for thirty-one (31) days and will terminate on the 32nd day if the required documentation is not submitted to the University (i.e., coverage will not be retroactively rescinded, but will terminate prospectively beginning on the 32nd day).

For more information, see *Other Events Ending Your Coverage* in Section 11, *When Coverage Ends*.

Note: This Plan does not cover Retired Employees, or individuals who meet the definition of Long-Term Disability Recipient (see Section 13, Glossary) who do not also meet the End-Stage Renal Disease requirements, above, their Dependents, the Surviving Spouse of an Employee, or the surviving Dependents of an Employee. These individuals may be eligible for coverage under a University Retiree and Disability Plan or UM Sponsored Group Medicare Advantage Plan. For more information on eligibility and coverage under the Retiree and Disability Plan or Medicare Advantage Plan, see each Plan's SPD.

Cost of Coverage

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

Contributions are payable monthly to the University. The payment of any Contribution shall not maintain participation beyond the date on which the next Contribution becomes payable.

Contributions are deducted from your paycheck. Employees on leave of absence without salary are required to make their Employee Contributions by cash payments during their leave. The completed benefit enrollment (via online or paper) is the authorization to the University to deduct the monthly Contributions from the salary of the Employee.

Contributions are not prorated. If participation begins on any day other than the first day of the month, monthly Contributions will begin on the first day of the month next following the Effective Date of participation (i.e., no Contributions will be due for the first partial month of participation). Monthly Contributions are paid during the month to which the Contributions relate.

Monthly Contributions for participation shall cease at the end of the month in which the Employee ceases work with the University (which is the day immediately preceding the Employee's termination date).

Contribution - Examples

Example 1:

You cease working for the University on January 31, which means your termination date is February 1. Your Contributions will cease on the last day of January, the month in which you last worked for the University.

Example 2:

You cease working for the University on February 1, which means your termination date is February 2. Your Contributions will cease on the last day of February, the month in which you last worked for the University.

Your Contributions are deducted on a before-tax basis for yourself, your Spouse and any eligible Dependent Children, which lowers the current amount of income tax you pay, unless you choose to contribute on an after-tax basis or are defaulted into the Healthy Savings Plan. For more details about how the before-tax feature works for you, refer to the Flexible Benefits SPD located on the UM System Office of Human Resources website.

Please note that when your Contributions are on a before-tax basis, certain Internal Revenue Service restrictions prohibit enrollment changes during the year unless the changes are due to a Family status change, and you notify the HR Service Center or your HR Generalist within thirty-one (31) days of the change. If you experience a family status change, you must complete and submit a Life Event through the University's self-service portal (myhr.umsystem.edu) within thirty-one (31) days of the event.

Note: Your Contribution for a Sponsored Adult Dependent will be on an after-tax basis unless the Sponsored Adult Dependent is a qualified tax dependent under IRS rules. The University paid Contribution portion of the Sponsored Adult Dependent will be subject to imputed income unless the Sponsored Adult Dependent is a qualified tax dependent under IRS rules.

The level of Contribution subsidy is limited to ten (10) Dependent Children. You will be required to pay the full Contribution cost for each Child that is enrolled beyond the maximum of ten (10).

Employees who have Coverage for over ten (10) Children as of December 31, 2001, will continue to receive Contribution support for all Children Covered as of that date. Any new Children, over the maximum of ten (10), who are enrolled on or after January 1, 2002, will require payment of the entire Contribution by the Employee.

Reimbursement Right

In the event (i) an Employee enrolls an ineligible individual (including themselves or any Dependents) under the Plan, or (ii) a covered Employee or Dependent becomes ineligible for coverage under the Plan and the Plan does not receive notification of an enrollment change within thirty-one (31) days of the qualifying event or qualifying family/employment status change, any claims paid on behalf of such ineligible individual, while such individual was ineligible, must be reimbursed to the Plan.

How to Enroll

To enroll or waive coverage, you must complete and submit the benefit enrollment (via online or paper) within thirty-one (31) days of the date you first become eligible for medical Plan coverage (hire or eligibility date). If you do not enroll or waive coverage, within thirty-one (31) days, you will be defaulted to the Healthy Savings Plan and your contribution will be deducted after-tax. In such event, you will need to wait until the next Annual Enrollment to add or remove dependents, unless you experience a change in family or employment status.

Each year during Annual Enrollment, you have the opportunity to review and change your medical election. If you do not actively submit a medical insurance choice during Annual Enrollment, you and your currently enrolled family members will remain in your current enrollment. If you experience a qualifying family/employment status change during the plan year, you may be eligible to make a coverage change (see “Changing Your Coverage”). Annual Enrollment is the only period of time when you will be able to change from one medical plan to another. Any changes you make during Annual Enrollment will become effective the following January 1.

If you are applying for coverage mid-year due to a Special Enrollment Right or qualifying family/employment status change (described below), you must complete and submit a Life Event through the University’s self-service portal (myhr.umsystem.edu) within thirty-one (31) days of the event. Otherwise, you must wait until the next Annual Enrollment to change your elections.

Dependents are only covered by this Plan if the Employee applies for such coverage and makes the required Contribution.

Even though an Employee has Dependent Coverage, the Employee must apply to cover any additional Dependents. Coverage will be provided only for those Dependents for whom the Employee has made such specific application.

Important

If you wish to change your coverage level (including beginning or ending Coverage or adding or dropping Dependents) following your marriage, birth, adoption of a Child, placement for adoption of a child or other family status change, you must submit a Life Event through the University’s self-service portal (myhr.umsystem.edu) within thirty-one (31) days of the event. Otherwise, you will need to wait until the next Annual Enrollment to change your elections.

When Coverage Begins

1. Newly Eligible Employee Participation

Employees, other than variable-hour, seasonal or part-time Employees, are eligible to participate in this Plan on the first day they are employed, provided the benefit enrollment (via online or paper) is submitted within thirty-one (31) days of the date of hire or eligibility. An Employee who does not actively enroll in a plan or waives coverage will automatically be defaulted into the Healthy Savings Plan on an after-tax basis.

If an Employee defaults and later wishes to waive coverage, they will have 60 days to waive coverage with a retro-effective date matching the Employee's hire or eligibility date provided they;

- submit a Healthy Savings Plan-After Tax Waiver Form within 60 days of date of hire or eligibility (available through HR Service Center); and
- have no claims while covered by the Plan.

For coverage retroactively waived, up to, but no more than, two months of Premiums will be refunded.

If the Employee does not satisfy all of the above requirements, they may still waive coverage; however, the waiver will not be effective until the first of the following month and no Premiums will be refunded.

Variable hour, seasonal, or part-time Employees and "subsidiary employees" who have been classified as variable hour, seasonable, or part-time Employees, are eligible to participate in this Plan during a designated "stability period" (as defined in Section 4980H of the Code and the regulations issued thereunder) immediately following a designated "measurement period" (as defined in Section 4980H of the Code and the regulations issued thereunder) during which such Employee worked thirty (30) hours or more on average per week. Refer to <http://umurl.us/PPACA> for more information.

Any person who is not an Employee as defined in this Plan, but who subsequently becomes an Employee (other than variable hour, seasonal, or part-time Employees and "subsidiary employees" who have been classified as variable hour, seasonable, or part-time Employees), shall be eligible to participate in this Plan on the effective date of such change of designation.

Coverage begins under the Plan on the later of:

- the Employee's date of hire, if written application is made within thirty-one (31) days after the Employee's date of hire.
- the first of the month coincident with or next following the date the Employee becomes eligible to participate (if the Employee was not eligible to participate on their date of hire), provided such Employee makes written application within thirty-one (31) days of the date on which the Employee becomes eligible and not more than thirty-one (31) days of return to Active Employment if the Employee was not Actively at Work on the date of eligibility.
- January 1 following an Annual Enrollment period, if written application is made during Annual Enrollment, if the Employee was not otherwise eligible to participate or failed to timely enroll on their date of hire or through a special enrollment period.
- If the Employee is not Actively at Work on the date Coverage would normally begin, the Coverage will not be effective until the Employee returns to full-time Active

Employment, unless the Employee is not Actively at Work due to their own health factor.

If the Employee is not Actively at Work due to their own health factor on the date the Employee would otherwise become a Participant, the date the Employee becomes a Participant will be determined without regard to the fact the Employee was not Actively at Work.

- for variable hour, seasonal, or part-time Employees and “subsidiary employees” who have been classified as variable hour, seasonable, or part-time Employees, the first day of the designated “stability period” (as defined in Section 4980H of the Code and the regulations issued thereunder), if the Employee makes written application during the designated “administrative period” (as defined in Section 4980H of the Code and the regulations issued thereunder) immediately preceding the applicable designated “stability period” (as defined in Section 4980H of the Code and the regulations issued thereunder). Refer to <http://umurl.us/PPACA> for more information.

In no event shall an Employee become a Participant prior to the beginning date of employment with the University.

2. Dependent Participation

A Dependent of an Employee is eligible to participate in the Plan on the later of:

- the date such Employee becomes a Participant; or
- the date the person becomes a Dependent of a participating Employee.

(A) A Dependent becomes a Participant as follows:

- on the same date that the Employee becomes a Participant, provided the Employee makes written application for such Dependent on or prior to the date the Employee became eligible to participate; or
- on the first of the month following the date of a Qualifying Family/Status Change, provided the Employee makes written application (including proof of relationship) for such Dependent within thirty-one (31) days of the date on which the Dependent becomes eligible and not more than thirty-one (31) days of the date of the Employee's return to work if the Employee is not Actively at Work.

(B) Unless the Employee is eligible for the “special enrollment period,” described below, an Employee who makes written application to cover a Dependent more than thirty-one (31) days after the date the Dependent becomes eligible for coverage, and an Employee who reapplies for coverage after the coverage of Dependents has automatically ceased because of failure to make the required Contribution, will be eligible to elect coverage during the next subsequent enrollment period or in accordance with Paragraph 3(A) of this Section or with the provisions covering a qualifying family/employment status change (see Paragraph 5 of this Section).

(C) Each Dependent who was covered under the policy of group insurance (or plan) superseded by this Plan on December 31, 1969, and who is eligible on January 1, 1970, shall continue to participate on and after January 1, 1970, subject to the terms

and conditions of this Plan.

- (D) Each Dependent who was covered under the group insurance superseded by this Plan on June 30, 1990, and who is eligible on July 1, 1990, shall continue to participate on or after July 1, 1990, subject to the terms and conditions of this Plan. If a Child or Children of an Employee are acquired while the Employee is participating but has no Dependent Coverage on Children, such Child or Children shall become Participants in accordance with Paragraph 3(A) of this Section or with the provisions covering Special Enrollment Rights (see Paragraph 4 of this Section) or a qualifying family/employment status change (Paragraph 5 of this Section).
- (E) If both Spouses (or an Employee and an individual who meets the criteria to be a Sponsored Adult Dependent) are participating as Employees and one such individual ceases to participate by reason of a change in employment status, that individual will become a Participant as a Dependent in accordance with Paragraph 3(A) of this Section or with the provisions covering Special Enrollment Rights (see Paragraph 4 of this Section) or a qualifying family/employment status change (Paragraph 5 of this Section).
- (F) If both Spouses participate as Employees and one has Children participating as Dependents, and if the Employee ceases to participate for any cause, the Children shall become Participants in accordance with Paragraph 3(A) of this Section or with the provisions covering Special Enrollment Rights (see Paragraph 4 of this Section) or a qualifying family/employment status change (Paragraph 5 of this Section).
- (G) Except in accordance with the provisions covering Special Enrollment Rights or a qualifying family/employment status change, an Employee may change their participation status with respect to Dependents only during the annual enrollment period designated by the University.

3. Special Enrollment Rights

- (A) If an Employee declines coverage for themselves or for an eligible Dependent while other health insurance or group health plan coverage is in effect, the Employee will be able to elect coverage for themselves and their Dependents in this Plan if the Employee or their Dependents lose eligibility for that other coverage (or if the employer stops contributing toward the Employee or their Dependents' other coverage), if the Employee requests coverage by making written application within thirty-one (31) days of the other coverage ending (or after the employer stops contributing toward the other coverage). Coverage will become effective the first of the month following the date coverage ends.
- (B) If an Employee declines coverage for themselves or for an eligible Dependent while Medicaid coverage or coverage under a state children's health insurance program is in effect, the Employee will be able to elect coverage for themselves and their Dependents in this Plan if the Employee or their Dependents lose eligibility for that other coverage, if the Employee requests coverage by making written application within sixty (60) days after the Employee's or their Dependents' coverage ends under Medicaid or a state children's health insurance program. Coverage will become effective the first of the month following the date coverage ends.

If an Employee acquires a new Dependent as a result of marriage, birth, adoption, or

placement for adoption or legal guardianship, the Employee will be able to elect coverage for themselves and their new Dependents, provided the Employee completes and submits a Life Event through the self-service portal (myhr.umsystem.edu) within thirty-one (31) days of the marriage, birth, adoption or placement for adoption or legal guardianship.

(C) Coverage will become effective as follows:

- in the case of birth or adoption or placement for adoption, on the date of the event, as applicable, and
- In the case of any other event, if the event occurs on the first day of the month, coverage will become effective on that date; otherwise, coverage will become effective on the first of the month following the date of the event.

If an Employee requests coverage in writing (including proof of relationship) for a Dependent, other than a Spouse, more than thirty-one (31) days after such Dependent first becomes eligible for coverage, the following rules will apply:

- If the Employee request (and proof of relationship) is received within one hundred eighty (180) days after the Dependent first becomes eligible, and such Dependent is a newborn or an adopted Child for whom specific additional Employee Contribution is required (i.e., Coverage for other Children does not already exist), coverage for such Dependent will be provided for thirty-one (31) days, beginning on the date of the birth or adoption (as applicable), will cease as of the 32nd day and then resume on the date the Employee's written request is received. If the Employee request for coverage (including proof of relationship) is not received within the one hundred eighty (180)-day period specified above, the Employee may request coverage during the next subsequent annual enrollment period designated by the University and coverage will be provided for thirty-one (31) days, beginning on the date of birth or adoption (as applicable), will cease as of the 32nd day and will resume as of the January 1 following receipt of the employee's request during the annual enrollment period.
- If the Employee request (including proof of relationship) is received within one hundred eighty (180) days after the Dependent first becomes eligible and such Dependent is a Child other than a newborn or adopted Child for whom specific additional Employee Contribution is required (i.e., Coverage for other Children does not already exist), coverage for such Child will become effective the first of the month following the date on which the benefit enrollment form is submitted to the HR Service Center or your HR Generalist. If the Employee request for coverage (including proof of relationship) is not received within the one hundred eighty (180)-day period specified above, the Employee may request coverage during the next subsequent annual enrollment period designated by the University, and coverage will become effective on the following January 1.
- If the Employee request (including proof of relationship) is received within 180 days after the Dependent first becomes eligible and the Dependent for whom coverage is requested is a Child for whom specific additional Employee

Contribution is not required (i.e., Coverage already exists for other eligible Children), coverage will be effective as follows:

- in the case of birth or adoption or placement for adoption, on the date of the event, as applicable, and
- in the case of any other event, on the date coverage is requested.

(D) If an Employee or their Dependents become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this Plan, the Employee will be able to elect coverage for themselves and their Dependents in this Plan if the Employee requests coverage by making written application within sixty (60) days after the Employee's or their Dependents' determination of eligibility for such assistance. Coverage will become effective the first of the month following the date coverage ends.

4. Qualifying Family/Employment Status Change

In the case of a qualifying family/employment status change, the Employee may change participation status for themselves and their Dependents by completing the required Life Event through the self-service portal (myhr.umsystem.edu), within thirty-one (31) days of the date of the qualifying family/employment status change, in which case the change will become effective as follows:

- in the case of a participation change involving the birth or adoption or placement of a child for adoption, the change will become effective on the date of the event, as applicable, and
- in the case of any other change, provided the Life Event has been completed, if the event occurs on the first day of the month, the change will become effective on that date; otherwise, the change will become effective on the first of the month following the date of the event.

For more information on what constitutes a qualifying family/employment status change, please refer to "Changing your Coverage," below.

5. 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 Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within forty-eight (48) hours of the day your coverage begins, or as soon as is reasonably possible, if you are inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on that day. Network Benefits are available only if you receive Covered Health Services from Network Providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family or employment status (i.e. qualifying event, family status change, etc.). The change in coverage must be consistent with the change in status (i.e., you cover your Spouse following your marriage, your child following an adoption, etc.). You may change from one plan to another

only during Annual Enrollment. The following are considered family/employment status changes for purposes of the Plan:

- change in legal marital status, including marriage, divorce, legal separation or annulment;
- termination of a Sponsored Adult Dependent Partnership;
- death of a Dependent;
- change in the number of Dependent Children who are eligible for coverage under this Plan as a result of death, birth, adoption or placement of a Child for adoption, legal guardianship, or a Child ceasing to be eligible or becoming eligible in accordance with the definitions of Child or Children and Dependent;
- change in the employment status of the Employee or Spouse or Sponsored Adult Dependent which involves the commencement or termination of employment;
- change in the work schedule of the Employee or Spouse or Sponsored Adult Dependent which involves an increase or decrease in work hours, a strike, a lockout or an unpaid leave of absence;
- 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;
- change of residence or worksite by the Employee or Spouse or Sponsored Adult Dependent;
- issuance to the University of a valid Notice of Order to Enroll, as described in the definition of Child or Children;
- change in entitlement to coverage for the Employee, Spouse, Sponsored Adult Dependent or Dependent Child under any group health coverage sponsored by a governmental or educational institution, including Medicare, Medicaid, Children's Health Insurance Program Coverage (CHIP), a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization, a State health benefits risk pool, or a foreign government group health plan;
- you or your Dependent become eligible for a contribution assistance subsidy under Medicare, Medicaid, or CHIP (you must contact your Benefit Representative within sixty (60) days of determination of subsidy eligibility);
- rehiring of an Employee by the University during the same year in which the Employee previously terminated employment by the University;
- with respect only to an Employee who specifically declined coverage under this Plan as a result of the existence of other coverage, a special enrollment period will be available to such Employee in the event such other coverage ends;
- significant change in health coverage of the Employee or Spouse or Sponsored Adult Dependent attributable to the Spouse's or Sponsored Adult Dependent's employment;

- significant change in the cost of coverage under another employer-sponsored health plan;
- significant change in the cost of coverage under this Plan;
- the addition of a new benefit package option or coverage option offered by the University;
- the elimination of a benefit package option or coverage option during a coverage period;
- leave of absence under the Family and Medical Leave Act of 1993 (FMLA);
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for contributions on a timely basis;
- the eligibility of an Employee, Spouse, or Dependent for COBRA continuation coverage under a Plan sponsored by the University;
- a court administrative order, judgment, or decree as described in *Section 12: QMCSO's*;
- 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);
- Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- a change in employment status of an Employee that results in a change from a reasonable expectation that the Employee will average at least thirty (30) hours of service per week to a reasonable expectation that the Employee will average less than thirty (30) hours of service per week after the change.

For purposes of this paragraph, an Employee satisfies the requirements of the above Qualified Family/Employment Status Change if:

- the Employee has been in an employment status under which the Employee was reasonably expected to average at least thirty (30) hours of service per week and there is a change in that Employee's status so that the Employee will reasonably be expected to average less than thirty (30) hours of service per week after the change, even if that reduction does not result in the Employee ceasing to be eligible under the Plan; and
 - the revocation of the election of coverage under the Plan corresponds to the intended enrollment of the Employee, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.
- the eligibility of an Employee for a special enrollment period to enroll in a Qualified Health Plan through a Marketplace, or an Employee seeks enrollment in a Qualified

Health Plan through a Marketplace during the Marketplace's annual open enrollment period.

For purposes of this paragraph, an Employee satisfies the requirements of the above Coverage Change if:

- the Employee is eligible for a special enrollment period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Employee seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and
- the revocation of the election of coverage under the Plan corresponds to the intended enrollment of the Employee and any related individuals who cease coverage due to the revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Unless otherwise noted above, if you wish to change your coverage, you must contact the HR Service Center or your HR Generalist within thirty-one (31) days of the event. Otherwise, you will need to wait until the next Annual Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected. For Participants on leave of absence (LOA) please refer to the LOA in Section 11 *When Coverage Ends*.

Note: Any child under age twenty-six (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. During Annual Enrollment, she elects not to participate in the University's medical plan, because their husband, Tom, has family coverage under their employer's medical plan. In June, Tom loses their job as part of a downsizing. As a result, Tom loses their eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under the University's medical Plan outside of Annual Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Copayment.
- Coinsurance.
- Out-of-Pocket Maximum.

Accessing Benefits

In the Healthy Savings Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any Benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, *Plan Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible, and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as out-of-Network Benefits.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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

Air Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this section.

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

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

The Claims Administrator has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons Covered under the Plan, the Plan reimburses a higher percentage of their fees.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network Provider, you may be eligible to receive Network Benefits when Covered Health Services are received from a non-Network Provider. In this situation, your Network Physician will notify UnitedHealthcare, and if UnitedHealthcare confirms those specific covered health services are not available from a Network Provider, UnitedHealthcare will work with you and your Network Physician to coordinate care through a non-Network Provider.

Looking for a Network Provider?

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

Network Providers

UnitedHealthcare or its affiliates arrange for Health Care Providers to participate in a Network.

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

Before obtaining services, you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the Claims Administrator. A directory of providers is available online at **www.myuhc.com** or by calling the telephone number on your ID card to request a copy. If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

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

If you are under the care of a non-Network provider on the date your coverage begins, you may be eligible for reimbursement at the Network level of Benefits with that provider for a period of time for certain acute medical or pregnancy situations. This transition period is available for specific medical services and for limited periods of time. You must apply for transition of care no later than thirty (30) days after your coverage begins. 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 call the number on your ID card. Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact UnitedHealthcare by calling the number on your ID card for assistance.

Do not assume that a Network Provider's agreement includes all Covered Health Services. Some Network Providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network Providers choose to be a Network Provider for only some of our products. Refer to your provider directory or contact UnitedHealthcare by calling the number on your ID card for assistance.

Designated Providers

If you have a medical condition that UnitedHealthcare believes needs special services, UnitedHealthcare may direct you to a Designated Provider chosen by UnitedHealthcare. If

you require certain complex Covered Health Services for which expertise is limited, UnitedHealthcare may direct you to a Network Provider that is outside your local geographic area.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Provider or other Provider chosen by UnitedHealthcare.

You or your Network Provider must notify UnitedHealthcare of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Provider. If you do not notify UnitedHealthcare in advance and if you receive services from a non-Network Provider (regardless of whether it is a Designated Provider), Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Limitations on Selection of Providers

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to provide and coordinate all of your future Covered Health Services. If you don't make a selection within thirty-one (31) days of the date you are notified, UnitedHealthcare will select a single Network Physician for you. In the event you do not use the selected Network Physician Covered Health Services will be paid as Non-Network Benefits.

Eligible Expenses

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

Eligible Expenses are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Designated Network and Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, except as described below, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.
 - For Covered Health Services that are **Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
 - For Covered Health Services that are **non-Ancillary Services received at certain Network facilities on a non-Emergency basis from non-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as**

described below, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- For Covered Health Services that are **Emergency Health Services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law, as described in the SPD.

Designated Network and Network Benefits

Eligible Expenses are based on the following:

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

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- **For non-Emergency Covered Health Services received at certain Network facilities from non-Network Physicians** when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Health Service Act with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen urgent medical needs arise at the time the services are provided), the Eligible Expense is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.

- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
- The amount determined by Independent Dispute Resolution (IDR).

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

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, you are not responsible, and a non-Network Physician may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Emergency Health Services provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in the SPD.

- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is based on one of the following in the order listed below as applicable:
 - The reimbursement rate as determined by a state *All Payer Model Agreement*.
 - The reimbursement rate as determined by state law.
 - The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the non-Network provider and the Claims Administrator.
 - The amount determined by *Independent Dispute Resolution (IDR)*.

IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the rates that would apply if the service was provided by a Network provider which is based on the Recognized Amount as defined in the SPD.

- **For Emergency ground ambulance transportation provided by a non-Network provider**, the Eligible Expense, which includes mileage, is a rate agreed upon by the

non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.

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

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

Advocacy Services

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

Please see Section 5, Plan Highlights to understand the impact on your Co-insurance and co-payment if you choose to use non-network providers in non-emergency situations.

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 amount of Eligible Expenses, or the Recognized Amount when applicable, you must pay each Calendar Year for Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the Calendar Year and the Annual Deductible

need only be met once per Calendar Year. Note that, for Family Coverage, the Family Deductible must be met before the Plan pays for any member of the Family who is enrolled in the Plan. Network and Non-Network Deductibles accumulate separately. Both Covered Health Services and Prescription Drugs accumulate toward the Deductible.

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

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

If an Employee and one or more Dependents, or if two or more Dependents are injured in the same Accident, all applicable Covered Charges arising out of the Accident will be combined and only one Calendar Year Deductible will apply to all such expenses incurred during the Calendar Year in which the Accident occurred.

Coinsurance

Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses or the Recognized Amount when applicable) each time you receive certain Covered Health Services.

Details about the way in which Eligible Expenses are determined appear in this section under the heading *Eligible Expenses*.

Coinsurance - Example

Let's assume that you receive Plan Benefits for outpatient Surgery from a Network Provider. Since the Plan pays 85% after you meet the Annual Deductible, you are responsible for paying the other 15%. This 15% is your Coinsurance.

Out-of-Pocket Maximum

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

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

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Plan Features	Applies to the Network Out-of- Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments, except for those Covered Health Services identified in the <i>Plan Highlights</i> table that do not apply to the Out-of-Pocket Maximum	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable.	No	No

SECTION 4 – PERSONAL HEALTH SUPPORT & PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program.
- Prior Authorization Requirements

Care Management

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

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

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

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

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. When the Claims Administrator is called as required, they will work with you to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy. As of the publication of this SPD, the Personal Health Support program includes:

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

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

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

Prior Authorization

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

It is recommended that you confirm with the Claims Administrator that all Covered Health Services listed in Section 6, *Additional Coverage Details* have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact the Claims Administrator to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact the Claims Administrator by calling the number on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Services for which you are required to obtain prior authorization are shown in Section 6, *Additional Coverage Details*.

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

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Contacting UnitedHealthcare or Personal Health Support is easy.
Simply call the number on your ID card.

Network providers are responsible for obtaining prior authorization from the Claims Administrator before they provide certain services to you.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from the Claims Administrator before you receive these services. In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided prior authorization.

Services for which you are required to obtain prior authorization are identified in Section 6, *Additional Coverage Details*, within each Covered Health Service Benefit description. Please note that prior authorization timelines apply. Refer to the applicable Benefit description to determine how far in advance you must obtain prior authorization.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to obtain authorization before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:

- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network Amounts	Non-Network Amounts*
Annual Deductible** <ul style="list-style-type: none"> • Individual. • Family (cumulative Annual Deductible). <p>The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in this table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.</p> <p>**Network and Non-Network Deductibles accumulate separately. Both Medical Expenses and Prescription Drugs accumulate toward the Deductible.</p>	<p>\$1,750</p> <p>\$3,500</p>	<p>\$3,500</p> <p>\$7,000</p>
Annual Out-of-Pocket Maximum <ul style="list-style-type: none"> • Individual. • Family (cumulative Out-of-Pocket Maximum). <p>The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the family Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the</p>	<p>\$3,750</p> <p>\$7,500</p>	<p>\$7,000</p> <p>\$14,000</p>

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Plan Features	Network Amounts	Non-Network Amounts*
<p>individual coverage Out-of-Pocket Maximum stated in this table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies. Network and Non-Network Deductibles accumulate separately. Both Medical Expenses and Prescription Drugs accumulate toward the Out-of-Pocket Maximum.</p> <p>The Annual Deductible and Coinsurance applies toward the Out-of-Pocket Maximums.</p>		
<p>Lifetime Maximum Benefit</p> <p>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.</p> <p>Generally, the following are considered to be essential benefits under the <i>Patient Protection and Affordable Care Act</i>:</p> <p>Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and Substance-Related and Addictive Disorder Services (including behavioral health treatment); Prescription Drug products; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.</p> <p>*See Section 3- <i>How the Plan Works</i>; sub-sections <i>Accessing Benefits</i> and <i>Eligible Expenses, for Non-Network Benefit</i> details.</p>	Unlimited	

Schedule of Benefits

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

Amounts which you are required to pay as shown below in the *Schedule of Benefits* are based on *Eligible Expenses* or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 13, *Glossary*.

Covered Health Services ¹	Participant Responsibility	
	Network	Non-Network*
Allergy Drops (Sublingual)	25% per vial after Annual Deductible	25% or more per vial after Annual Deductible
Allergy Injections	15% after Annual Deductible	35% or more after Annual Deductible
Ambulance Services <ul style="list-style-type: none"> Emergency Ambulance <p>Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, <i>How the Plan Works</i>.</p> <ul style="list-style-type: none"> Non-Emergency Ambulance <p>Ground or air ambulance, as the Claims Administrator determines appropriate.</p> <p>Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as</p>	<i>Ground Ambulance</i> 15% after Annual Deductible <i>Air Ambulance</i> 15% after Annual Deductible	<i>Ground Ambulance</i> Same as Network <i>Air Ambulance</i> Same as Network
	<i>Ground Ambulance</i> 15% after Annual Deductible <i>Air Ambulance</i> 15% after Annual Deductible	<i>Ground Ambulance</i> Same as Network <i>Air Ambulance</i> Same as Network

¹ In general, your Network Provider must obtain prior authorization from the Claims Administrator or Personal Health Support, as described in Section 4, *Personal Health Support* before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

*See Section 3- *How the Plan Works*; sub-sections *Accessing Benefits* and *Eligible Expenses, for Non-Network Benefit* details.

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Covered Health Services ¹	Participant Responsibility	
	Network	Non-Network*
described in Section 3, <i>How the Plan Works</i> .		
Blood Plasma	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Clinical Trials - Routine Patient Care Costs Benefits are available when the Covered Health Services are provided by either Network or non-Network Providers.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Cellular and Gene Therapy For Network Benefits, Cellular or Gene Therapy services must be received from a Designated Provider.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section	Non-Network Benefits are not available.
Congenital Heart Disease (CHD) Surgeries Network and Non-Network Benefits under this section include only the inpatient Facility charges for the congenital heart disease (CHD) Surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under	15% after Annual Deductible	35% or more after Annual Deductible

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Covered Health Services ¹	Participant Responsibility	
	Network	Non-Network*
each Covered Health Service category in this section.		
Dental Hospital & Anesthesia Services	15% after Annual Deductible	35% or more after Annual Deductible
Dental Services - Accident Only	15% after Annual Deductible	35% or more after Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.
Diabetes Self-Management Items <ul style="list-style-type: none"> • Diabetes equipment. • Diabetes supplies. 	Benefits for diabetes equipment will be the same as those stated under <i>Durable Medical Equipment</i> in this section. For diabetes supplies the Benefit is 15% after you meet the Annual Deductible.	Benefits for diabetes equipment will be the same as those stated under <i>Durable Medical Equipment</i> in this section. For diabetes supplies the Benefit is 35% after you meet the Annual Deductible.
Durable Medical Equipment (DME) See Section 6, Additional Coverage Details, for limits.	15% after Annual Deductible	35% or more after Annual Deductible
Emergency Health Services - Outpatient	15% after Annual Deductible	Same as Network

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Covered Health Services ¹	Participant Responsibility	
	Network	Non-Network*
<p>If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead.</p> <p>Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under <i>Eligible Expenses</i> in Section 3: <i>How the Plan Works</i>.</p>		
<p>Enteral Nutrition</p> <p>See Section 6, Additional Coverage Details, for limits.</p>	15% after Annual Deductible	35% or more after Annual Deductible
<p>Family Planning</p>	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
<p>Gender Dysphoria</p>	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the <i>Schedule of Benefits</i> and in the <i>Prescription Drug SPD</i> located at the end of this document.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the <i>Schedule of Benefits</i> and in the <i>Prescription Drug SPD</i> located at the end of this document.
<p>Hearing Aids</p> <p>See Section 6, <i>Additional Coverage Details</i>, for limits</p>	15% after Annual Deductible	Non-Network Benefits are not available.

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Covered Health Services ¹	Participant Responsibility	
	Network	Non-Network*
Home Health Care	15% after Annual Deductible	35% or more after Annual Deductible
Hospice Care	15% after Annual Deductible	35% or more after Annual Deductible
Hospital - Inpatient Stay	15% after Annual Deductible	35% or more after Annual Deductible
Implants and Related Medical Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Lab, X-Ray and Minor Diagnostics - Outpatient <ul style="list-style-type: none"> • Lab Testing - Outpatient. • X-Ray and Other Minor Diagnostic Testing - Outpatient. • Any medically necessary diagnostic and supplemental breast examinations using diagnostic mammography, breast magnetic resonance imaging, or breast ultrasound 	15% after Annual Deductible 15% after Annual Deductible None after Annual Deductible	35% or more after Annual Deductible 35% or more after Annual Deductible Non-Network Benefits are not available
Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	15% after Annual Deductible	35% or more after Annual Deductible
Mental Health Services <ul style="list-style-type: none"> • Inpatient. • Outpatient 	15% after Annual Deductible <u>Office visit</u>	35% or more after Annual Deductible <u>Office visit</u>

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Covered Health Services ¹	Participant Responsibility	
	Network	Non-Network*
	15% after Annual Deductible <u>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</u> 15% after Annual Deductible	35% or more after Annual Deductible <u>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</u> 35% or more after Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorders <ul style="list-style-type: none"> • Inpatient. • Outpatient 	15% after Annual Deductible <u>Office visit</u> 15% after Annual Deductible <u>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</u> 15% after Annual Deductible <u>Intensive Behavioral Therapy</u> 15% after Annual Deductible	35% or more after Annual Deductible <u>Office visit</u> 35% or more after Annual Deductible <u>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</u> 35% or more after Annual Deductible <u>Intensive Behavioral Therapy</u> 35% or more after Annual Deductible
Newborn Care	Depending upon where the Covered Health Service is provided, Benefits	Depending upon where the Covered Health Service is provided, Benefits will

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Covered Health Services ¹	Participant Responsibility	
	Network	Non-Network*
	will be the same as those stated under each Covered Health Service category in this section.	be the same as those stated under each Covered Health Service category in this section.
Nutritional Counseling	15% after Annual Deductible	35% or more after Annual Deductible
Obesity Surgery See Section 6, <i>Additional Coverage Details</i> for limits.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. Also there is an additional \$2,500 Copayment toward the cost of the bariatric Surgery in addition to all other Deductibles, Copayments, or Coinsurance that may apply under the Plan.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section. Also there is an additional \$2,500 Copayment toward the cost of the bariatric Surgery in addition to all other Deductibles, Copayments, or Coinsurance that may apply under the Plan.
Ostomy Supplies	15% after Annual Deductible	35% or more after Annual Deductible
Pharmaceutical Products - Outpatient	15% after Annual Deductible	35% or more after Annual Deductible
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Eligible Expenses will be	15% after Annual Deductible	35% or more after Annual Deductible

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Covered Health Services ¹	Participant Responsibility	
	Network	Non-Network*
determined as described in Section 3, <i>How the Plan Works</i> , under <i>Eligible Expenses</i> .		
Physician's Office Services - Sickness and Injury	15% after Annual Deductible	35% or more after Annual Deductible
Podiatry Care	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Pregnancy – Maternity Services A separate Calendar year Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. A separate Deductible will apply if, due to complications, the newborn is admitted under their own eligibility.	15% After Annual Deductible	35% or more after Annual Deductible
Preventive Care Services <ul style="list-style-type: none"> Physician Office Services. Lab, X-ray or Other Preventive Tests. Breast Pumps. 	0% 0% 0%	35% or more after Annual Deductible 35% or more after Annual Deductible 35% or more after Annual Deductible
Private Duty Nursing – Outpatient	15% after Annual Deductible	35% or more after Annual Deductible
Prosthetic Devices	15% after Annual Deductible	35% or more after Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each

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Covered Health Services ¹	Participant Responsibility	
	Network	Non-Network*
	each Covered Health Service category in this section.	Covered Health Service category in this section.
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, <i>Additional Coverage Details</i> , for visit limits.	15% after Annual Deductible	35% or more after Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	15% after Annual Deductible	35% or more after Annual Deductible
Services Provided to Residents of Long-term Care Facilities	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, <i>Additional Coverage Details</i> , for limits	15% per Inpatient Stay after Annual Deductible	35% or more per Inpatient Stay after Annual Deductible
Substance-Related and Addictive Disorder <ul style="list-style-type: none"> • Inpatient. • Outpatient 	15% after Annual Deductible <u>Office visit</u> 15% after Annual Deductible <u>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</u>	35% or more after Annual Deductible <u>Office visit</u> 35% or more after Annual Deductible <u>All Other Outpatient Services, including Partial Hospitalization/Day Treatment/High Intensity Outpatient/Intensive Outpatient Treatment</u>

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Covered Health Services ¹	Participant Responsibility	
	Network	Non-Network*
	15% after Annual Deductible	35% or more after Annual Deductible
Surgery - Outpatient	15% after Annual Deductible	35% or more after Annual Deductible
Therapeutic Treatments - Outpatient	15% after Annual Deductible	35% or more after Annual Deductible
Transplantation Services Non-Network Benefits include services provided at a Network Provider that is not a Designated Provider and services provided at a non-Network Provider. See Section 6, <i>Additional Coverage Details</i> , for Kidney Transplants.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Urgent Care Center Services	15% after Annual Deductible	35% or more after Annual Deductible
Urinary Catheters	15% after Annual Deductible	35% or more after Annual Deductible
Vertebral Body Tethering (VBT)	15% after Annual Deductible	35% or more after Annual Deductible
Virtual Care Services Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling the telephone number on your ID card.	15% after Annual Deductible	Non-Network Benefits are not available.
Wigs	15% after Annual Deductible	35% or more after Annual Deductible

In general, your Network Provider must obtain prior authorization from the Claims Administrator or Personal Health Support, as described in Section 4, *Personal Health Support* before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information. *See Section 3- *How the Plan Works*; sub-sections *Accessing Benefits* and *Eligible Expenses*, for *Non-Network Benefit* details.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

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

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

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

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

Allergy Injections

The Plan covers services for allergy testing, diagnosis, treatment, allergy serum and/or drops and the administration of injections and/or drops.

Coverage is provided for allergy and dermatology services and supplies ordered by and provided by or under the direction of a Physician in the Provider's office.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 13, *Glossary* for the definition of Emergency.

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

Coverage is provided for Non-Emergency transportation by professional ambulance other than air ambulance to and from a Hospital in cases where, for medical reasons, transportation cannot be by private automobile or common carrier, provided that the distance to or from the Hospital or Physician is not more than one hundred fifty (150) miles.

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

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more Cost-Effective Acute care Facility.
- 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.

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 chronic Sickness.
- "Sub-Acute Facility" means a Facility that provides intermediate care on short-term or long-term basis.

Prior Authorization Requirement

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

If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

Cellular and Gene Therapy

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

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

Clinical Trials - Routine Patient Care Costs

Benefits are available for routine patient care costs incurred during participation in a qualifying Clinical Trial for the treatment of cancer or other life-threatening disease or

condition. For purposes of this Benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- Routine Patient Costs for any Clinical Trial that does not meet the criteria.
- The cost of any non-Covered Expense a Participant may require in conjunction with the Clinical Trial (e.g. transportation, lodging, Custodial Care) and the administrative costs associated with managing the Clinical Trial.
- Nutritional counseling when provided by a registered dietician or a Physician and in connection with diabetes, Morbid Obesity, coronary artery disease and hyperlipidemia.
- Experimental or Investigational drugs, service(s), or devices. 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 UnitedHealthcare's medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

- 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* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
 - The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
 - The Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial.
 - The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement

For Non-Network Benefits You must obtain prior authorization as soon as the possibility of participation in a Clinical Trial arises. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

Congenital Heart Disease (CHD) Surgeries

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

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

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

- Outpatient diagnostic testing.
- Evaluation.
- Surgical interventions.
- Interventional cardiac catheterizations (insertion of a tubular device in the heart).
- Fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology).
- Approved fetal interventions.

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

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

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

To receive Benefits under the CHD program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CHD program if CHD provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a CHD Surgery arises. If you fail to obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction. It is important that you notify the Claims Administrator regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Dental Hospital & Anesthesia Services

Coverage for the administration of general anesthesia and Hospital charges for dental care provided to the following Participants when authorized in advance:

- A Child under the age of five (5).
- A person who is severely disabled.
- A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental treatment is required.

This Coverage is provided regardless of whether the dental services are provided in a Hospital, Surgical Center or office.

Prior Authorization Requirement

Please remember that you must obtain prior authorization from the Claims Administrator as soon as possible. If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

Dental Services - Accident Only

Dental services are covered by the Plan when treatment is necessary because of Accidental damage, when treatment is started within three (3) months of injury, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within twelve (12) months of the accident.

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

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

- Direct treatment of Acute Traumatic Injury.

- Dental services related to medical transplant procedures.
- Initiation of immunosuppressive (medication used to reduce inflammation and suppress the immune system).
- Direct treatment of Acute traumatic Injury, cancer or cleft palate.

Coverage includes only Authorized oral surgical services limited to the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip or tongue; incision of accessory sinuses, mouth, salivary glands or ducts; reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect.

Coverage is provided for diseases of the mouth, unless the condition is due to dental disease or of dental origin.

Coverage is provided for services by a licensed dentist for the care, repair, removal, replacement or treatment of the teeth or surrounding tissues when necessitated by damage to teeth or surrounding tissues as a result of an Injury.

Dental implants are Covered if Medically Necessary as a result of Injury or Sickness.

Teeth do not need to be sound and natural.

The Plan pays for treatment of Accidental Injury only for:

- Coverage limited to the functional restoration of structures and treatment as a result of trauma resulting in fracture of jaw or laceration of mouth, tongue or gums.
- Services are Covered for the removal of tumors and cysts of the jaws, lips, cheeks, tongue, roof and floor of the mouth, and removal of bony growths of the jaw, soft and hard palate.
- Coverage is provided for services by a licensed dentist for the care, repair, removal, replacement or treatment of the teeth, or surrounding tissues when necessitated by damage to teeth or surrounding tissues as a result of an Injury.

Prior Authorization Requirement

Please remember that you must obtain prior authorization from the Claims Administrator as soon as possible, but at least five (5) business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

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

The plan covers insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:

- Insulin pumps are subject to all the conditions of coverage stated under *Durable Medical Equipment*.
- Blood glucose monitors.
- Insulin syringes with needles.
- Blood glucose and urine test strips.
- Ketone test strips and tablets.
- Lancets and lancet devices.
- One (1) pair of therapeutic shoes, including fitting of shoes and/or inserts, per Calendar Year. Benefits are paid the same as Orthotic Appliances
- One (1) pair of custom molded shoe orthotics per Calendar Year. Benefits are paid the same as Orthotic Appliances
- Foot care in connection with clipping nails or treating corns and calluses related to diabetic foot disease or peripheral neuropathy.
- Self-management training, excluding extended education classes.

Prior Authorization Requirement

You must obtain prior authorization before obtaining any Durable Medical 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). If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

Durable Medical Equipment (DME)

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

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

If more than one (1) piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one (1) insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.

- Standard hospital beds.
- Delivery pumps for tube feedings.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Continuous passive motion devices after Surgery.
- Compression stockings.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section.
- Foot Orthotics.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or Acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Orthotic Appliances.

The following Orthotic Appliances are covered when prescribed by a Physician:

- Cranial helmets.
- One (1) pair of foot orthotics per Calendar Year.
- One (1) pair of therapeutic shoes per Calendar Year for diabetic foot disease or peripheral neuropathy.

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

Benefits also include dedicated speech generating devices and tracheo-esophageal voice devices required for treatment of severe speech impairment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of these devices are available only after completing a required three (3)-month rental period.

Note: DME is different from Prosthetic Devices - see *Prosthetic Devices* in this section.

Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one (1) device during the entire period of time a Covered Person is enrolled under the Plan. Benefits for repair/replacement are limited to once every three (3) years.

To receive Network Benefits, you must obtain the Durable Medical Equipment or orthotic from the vendor UnitedHealthcare identifies or from the prescribing Network Physician.

Replacement is covered when prescribed by a Physician due to normal routine wear and tear.

At the Claims Administrator's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three (3)-year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three (3)-year timeline for replacement.

Prior Authorization Requirement

For Non-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). If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

Emergency Health Services - Outpatient

The Plan's Medical Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment. Medical Emergency definition is described in Section 13, *Glossary*.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified within one (1) business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date your Physician determines it is medically appropriate to transfer you to a Network Hospital, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *Plan Highlights*.

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

Enteral Nutrition

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

Family Planning

Covered Services include:

- Counseling, treatment and follow-up.
- Information on birth control.
- Insertion and removal of intra-uterine devices and Norplant and measurement for contraceptive diaphragms.

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*.

Prior Authorization Requirement for Surgical Treatment

For Non-Network Benefits you must obtain prior authorization as soon as the possibility of surgery arises. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

In addition, for Non-Network Benefits you must contact the Claims Administrator twenty-four (24) hours before admission for an Inpatient Stay.

It is important that you notify the Claims Administrator as soon as the possibility of surgery arises. Your notification allows the opportunity for the Claims Administrator to provide you with additional information and services that may be available to you and are designed to achieve the best outcomes for you.

Prior Authorization Requirement for Non-Surgical Treatment

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

Hearing Exams, Services and Aids/Devices

For all covered members: There is coverage for ear examinations, the fitting of hearing aids and the cost of the appliances if due to Illness or Injury to physical organs or parts or dependent children with developmental delays. This includes, but is not limited to: diabetes, stroke, high blood pressure, heart disease, Menier's disease and tumors that cause hearing loss.

Coverage is as follows:

- Medically Necessary hearing screenings to determine hearing loss, including audiograms, are limited to one screening per Participant per calendar year. Medically Necessary treatment for hearing loss is also covered;

- Network Care only;
- Cochlear implants are covered for any member who meets the plan guidelines, regardless of age.
- Cochlear implant therapy is limited to thirty (30) visits per Calendar Year.

Hearing Aids

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

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

Benefits are also provided for certain *U.S. Food and Drug Administration (FDA)* approved over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- A written prescription or other order.

If more than one (1) type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will pay only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for paying any difference in cost.

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

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

The Benefits are limited to one (1) appliance per ear ever two calendar years.

Home Health Care

Covered Health Services are services a Home Health Agency provides if you need care in the home when all of the following requirements are met:

- The service is ordered by a Physician.
- Services required are of a type which can only be performed by a licensed nurse, physical therapist, speech therapist or occupational therapist.
- The services are a substitute or alternative to hospitalization.
- Part-time intermittent services are required.
- A treatment plan has been established and periodically reviewed by the ordering Physician.
- The agency rendering services is Medicare certified and licensed by the state of location.

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

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five (5) business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

Hospice Care

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

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator five (5) business days before admission for an Inpatient Stay in a Hospice Facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- Non-Physician services and supplies received during an Inpatient Stay.

- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists, general nursing care and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice or when no other option is available.

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

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

Prior Authorization Requirement

Please remember for Non-Network Benefits, for:

- A scheduled admission, you must obtain prior authorization five (5) business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a \$500 reduction.

Implants and Related Medical Services

Implant devices and related implantation Medical Services including, but not limited to, implants for the purpose of contraception and implants for the delivery of medication when provided by or under the direction of a Physician, in accordance with the Claims Administrator's guidelines and approved in advance by the Claims Administrator, are Covered. Dental implants are Covered if Medically Necessary as a result of Injury or Sickness.

Prior Authorization may be required for some services.

Lab, X-Ray and Diagnostics - Outpatient

The plan covers services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office including:

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

Benefits under this section include:

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

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

Prior Authorization Requirement

For Non-Network Benefits for Genetic Testing, sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization from the Claims Administrator five (5) business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

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

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

Benefits under this section include:

- The Facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

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

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator for CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, five (5) business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office. All services must be provided by

or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

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

Benefits include the following services:

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

The Mental Health/Substance-Related and Addictive Disorder Administrator determines coverage for all levels of care. Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorder Administrator for assistance in locating a provider and coordination of care at 1-844-634-1237.

Special Mental Health Programs and Services

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

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain prior authorization from the Claims Administrator five (5) business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation.

If you fail to obtain prior authorization from the MH/SUD Administrator as required, Benefits will be subject to a \$500 reduction.

Neurobiological Disorders - Autism Spectrum Disorder Services

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

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

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

Benefits include the following levels of care:

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

Services include the following:

- Diagnostic evaluations, assessment and treatment and/or procedures.
- Medication management.

- Individual, family, and group therapy.
- Crisis intervention.

The Mental Health/Substance-Related and Addictive Disorders Administrator determines coverage for all levels of care. Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorders Administrator for assistance in locating a provider and coordination of care.

Enhanced Autism Spectrum Disorder

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

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

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorder Administrator for assistance in locating a provider and coordination of care.

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled admission for Neurobiological Disorders – Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility), you must obtain authorization from the Claims Administrator (5) five business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Treatment programs; psychological testing; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*.

If you fail to obtain prior authorization from or provide notification to the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

Newborn Care

The Covered Services for eligible newborn Children shall consist of Coverage for Injury or Sickness, including Medically Necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, and transportation costs of the newborn to and from the nearest Facility that is appropriately staffed and equipped to treat the newborn's condition.

Coverage is provided for all newborns to be tested or screened for phenylketonuria (PKU) and such other common metabolic or genetic diseases.

Coverage is also provided for newborn hearing screening examinations, any necessary re-screening, audiological assessment and any requisite follow-up.

Prior Authorization is required for non-Emergency or non-urgent transportation to another Facility.

Nutritional Counseling

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

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

Some examples of such medical conditions include, but are not limited to:

- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout (a form of arthritis).
- Renal failure.
- Phenylketonuria (a genetic disorder diagnosed at infancy).
- Hyperlipidemia (excess of fatty substances in the blood).
- Diabetes.
- Morbid Obesity.

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

Obesity Surgery

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

- The individual has been a Participant under any University of Missouri Medical Benefits Plan for a period of at least three (3) consecutive years immediately prior to surgery.
- The Participant is at least twenty-one (21) years of age.
- The Participant has a Body Mass Index equal to or greater than 35 and said index has been met for the three (3) years prior to the date of Surgery.
- The Participant has at least one (1) co-morbidity that is a direct complication of obesity and that has been previously unsuccessfully treated (this requirement is waived for individuals with a Body Mass Index greater than 40).
- The Participant has, within the 24 months prior to Surgery, previously completed one (1) Physician-supervised weight loss attempt, for a duration no less than six months, that included behavioral therapy, diet changes, alteration of physical activity and pharmacotherapy when indicated and has been unsuccessful in this effort.

If you have had obesity surgery under the University of Missouri's medical plan, band manipulations will be covered without an additional \$2,500 copay. If your obesity surgery was performed under a non-university medical plan, the \$2,500 copay will apply for the first band manipulation. Additional band manipulations will not be assessed the \$2,500 copay.

Benefits are available for obesity Surgery services that meet the definition of a Covered Health Service, as defined in Section 13, *Glossary* and are not Experimental or Investigational or Unproven Services.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization as soon as the possibility of obesity surgery arises. If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction. In addition, for Non-Network Benefits you must contact the Claims Administrator twenty-four (24) hours before admission for an Inpatient Stay.

It is important you notify the Claims Administrator regarding your intention to have Surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

- Deodorants.
- Filters
- Lubricants.
- Tape.
- Appliance cleaners.
- Adhesive
- Adhesive remover.

Pharmaceutical Products - Outpatient

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

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

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

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

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

Covered Health 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 an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

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

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

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

Please Note

Your Physician does not have a copy of this SPD and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

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

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

- Forty-eight (48) hours for the mother and newborn child following a vaginal delivery.
- Ninety-six (96) hours for the mother and newborn child following a cesarean section delivery.

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

Limitations:

- Such election must be made at the time the Participant files their first claim in each Calendar Year.

- Charges made by a Physician with respect to a Pregnancy shall not be subject to the terms of such election.
- Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.
- Medical complications have arisen from an Abortion in which event those items required as a result of such medical complications shall be deemed to be Covered Expenses.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than forty-eight (48) hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

Preventive Care Services

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

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one (1) breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. Benefits for breast pumps also include the cost of purchasing one (1) breast pump per Pregnancy in conjunction with

childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

If more than one (1) breast pump can meet your needs, Benefits are available only for the most cost-effective pump. The Claims Administrator will determine the following:

- Which pump is the most Cost-Effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

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

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

- Routine lab tests.
- Diagnostic consults to prevent disease and detect abnormalities.
- Diagnostic radiology and nuclear imaging procedures to screen for abnormalities.
- Breast cancer screening and Genetic Testing.
- Tests to support cardiovascular health.

These additional services are paid under the preventive care Benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

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

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining a breast pump that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

Private Duty Nursing - Outpatient

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

The person cannot ordinarily reside in the participant's home or be a relative of the participant. For this purpose, relatives are considered the participant's spouse, children, brothers, sisters, parents of the participant or spouse.

Prosthetic Devices

Benefits are paid by the Plan for external Prosthetic Devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and noses.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Coverage will be provided for replacement of Prosthetic Devices, which become non-functional and non-repairable due to normal, routine wear and tear when prescribed by a Physician.

Prosthetics will be replaced yearly for documented growth in a Child requiring replacement.

The Plan will only cover one (1) device when Prosthetic Device placements require a temporary and then a permanent placement.

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

If more than one (1) Prosthetic Device can meet your functional needs, Benefits are available only for the Prosthetic Device that meets the minimum specifications for your needs. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a Prosthetic Device that exceeds these minimum specifications, the Plan will pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen Prosthetic Devices.

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

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization from the Claims Administrator before obtaining Prosthetic Devices that exceeds \$1,000 in cost per device. If prior authorization is not obtained as required, Benefits will be subject to a \$500 reduction.

Reconstructive Procedures

Reconstructive procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function

for an organ or body part. Reconstructive procedures include Surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

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

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

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid Surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 13, *Glossary*.

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

Prior Authorization Requirement

For Non-Network Benefits for:

- A scheduled Reconstructive Procedure, you must obtain prior authorization from the Claims Administrator (5) five business days before a scheduled Reconstructive Procedure is performed.
- A non-scheduled Reconstructive Procedure, you must provide notification within one (1) business day or as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a \$500 reduction.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to

- Physical therapy.
- Occupational therapy.
- Manipulative/Chiropractor Treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Pulmonary rehabilitation.
- Cardiac rehabilitation, if:
 - There is documentation of an existing cardiac or pulmonary problem such as post myocardial infarction, stable angina pectoralis, post coronary artery bypass, emphysema, chronic bronchitis, bronchiectasis, post lung cancer Surgery or other cardiac or pulmonary problems of similar magnitude;
 - The Program is prescribed and followed by the attending Physician with progress reports being furnished by said Physician;
 - The Program is under the overall supervision of a Physician;
 - The Program includes appropriate monitoring and Emergency equipment administered by professionals trained in its use; and

In no event will any charge for membership fees or dues charged by a health club or YMCA be included as Covered expenses.

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

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

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

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

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

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

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist; and
- 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, educational/vocational training and residential treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals is not a habilitative service.

The Plan may require the following be provided:

- medical records,
- other necessary data to allow the Plan to prove medical treatment is needed.

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

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

Benefits are limited to:

- Sixty (60) visits per Calendar Year for physical, occupational and speech therapy combined.
- Thirty-six (36) visits in a twelve (12)-week period per incident for pulmonary rehabilitation therapy.
- Thirty-six (36) visits in a twelve (12) -week period per incident for Phase II Cardiac Rehabilitation Therapy.
- Twenty-six (26) visits per Calendar Year for Manipulative Treatment.
- Thirty (30) visits per Calendar Year for post-cochlear implant aural therapy.

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

Services Provided to Residents of Long-term Care Facilities

If the Participant is a resident of a licensed long-term care Facility or a continuing care retirement community, such Participant has the option of receiving Medically Necessary services Covered by this provision in the long-term care Facility that serves as the Participant's primary residence if the following conditions apply:

- the Facility is willing and able to provide the Covered Service to the Participant;
- the Facility and its Providers meet the requisite licensing and training standards required under applicable state law;
- the Facility is certified through Medicare; and
- the Facility and its Providers agree to abide by the terms and conditions of the Claims Administrator's contracts with similar Providers, abide by patient protection standards and requirements imposed by state and federal law, and meet the quality standards of the Claims Administrator for similar Providers. The services Covered under this provision include, but are not limited to, Skilled Nursing Care, rehabilitative and other therapy services, and post-Acute care, as needed.
- The Plan may deliver the services Covered under this provision in the Participant's resident Facility.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Coverage is provided for a colorectal cancer exam and related laboratory testing for any asymptomatic person Covered under this Plan pursuant to the Claims Administrator's criteria, which are in accordance with the current CDC guidelines.

Benefits under this section include:

- The Facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

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

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

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

Benefits are available only if both of the following are true:

- The initial Confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost-Effective alternative to an Inpatient Stay in a Hospital.
- The Covered Person will receive Skilled Care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

- It 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.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

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

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 13, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to ninety (90) days per Calendar Year.

Prior Authorization Requirement

Please remember for Non-Network Benefits for:

- A scheduled admission, you must obtain prior authorization five (5) business days before admission.
- A non-scheduled admission, you must provide notification as soon as is reasonably possible.

If authorization is not obtained as required, or notification is not provided, Benefits will be subject to a \$500 reduction.

Substance-Related and Addictive Disorders Services

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

Benefits include the following levels of care:

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

Benefits include the following services:

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

The Mental Health/Substance-Related and Addictive Disorder Administrator determines coverage for all levels of care. Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

You are encouraged to contact the Mental Health/Substance-Related and Addictive Disorder Administrator for assistance in locating a provider and coordination of care at 1-844-634-1237.

Prior Authorization Requirement

For Non-Network Benefits for:

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

In addition, for Non-Network Benefits you must obtain prior authorization from the Claims Administrator before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment/High Intensity Outpatient; Intensive Outpatient Treatment programs; psychological testing.

If you fail to obtain prior authorization from or provide notification as required, Benefits will be subject to a \$500 reduction.

Special Substance-Related and Addictive Disorder Programs and Services

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

Surgery - Outpatient

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

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of Surgical Procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

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

Prior Authorization Requirement

For Non-Network Benefits for sleep apnea and orthognathic surgeries you must obtain prior authorization from the Claims Administrator five (5) business days before scheduled services are received or, for non-scheduled services, within one (1) business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction.

Therapeutic Treatments - Outpatient

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

Hemodialysis and peritoneal dialysis services are Covered Services if provided by outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies and maintenance will be a Covered Service.

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

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

Benefits under this section include:

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

Prior Authorization Requirement

- For Non-Network Benefits for all outpatient therapeutics you must obtain prior authorization five (5) business days before scheduled services are received or, for non-scheduled services, within one (1) business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, IV infusion, intensity modulated and MR-guided focused ultrasound.
- If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Benefits are available to the donor and the recipient when the recipient is covered under this Plan. Donor costs that are directly related to organ removal or procurement are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

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.

Transplantation services including evaluation for transplant, organ procurement and donor searches and transplantation procedures may be received at a Designated Provider, Network Provider that is not a Designated Provider or a non-Network Provider.

Services and supplies for transplants are covered at the in-network benefit level when performed at a designated provider coordinated by United Resource Network (URN) Transplant Coordination. Services received at a non-designated transplant Facility will be covered at the out-of-network (non-network) benefit level. Kidney Transplants may be performed at a Designated Provider or The University of Missouri Health System in order to receive the in-network benefit level.

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

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not obtain prior authorization from the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

In addition, for Non-Network Benefits you must contact the Claims Administrator twenty-four (24) hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Support in the event of serious Sickness

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

Travel

The plan pays for services received outside the continental United States that would otherwise be covered within continental United States. Services rendered will be covered at the out-of-network (non-network) benefit level, unless they are considered a Medical Emergency, defined in Section 13, Glossary, then they will be covered at the in-network (network) benefit level.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 13, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Urinary Catheters

Benefits are provided for external, indwelling and intermittent urinary catheters for incontinence or retention. Benefits include related urologic supplies for indwelling catheters limited to:

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

Vertebral Body Tethering (VBT)

The Plan pays for vertebral body tethering for scoliosis and related services.

The Plan pays for revision, replacement, or removal of vertebral body tethering for scoliosis when there are complications associated with the device (for example, tether breakage or overcorrection).

Virtual Care Services

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

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

Benefits are available for the following:

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

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

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

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis only for loss of hair resulting from Sickness or Injury.

Prior Authorization Requirement

For Non-Network Benefits you must obtain prior authorization if the Wig exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be subject to a \$500 reduction

SECTION 7 – CLINICAL PROGRAMS & RESOURCES

What this section includes:

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

- Consumer Solutions and Self-Service Tools.
- Disease Management Services.
- Complex Medical Conditions Programs and Services.

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

- Take care of yourself and your family members.
- Manage a chronic health condition.
- Navigate the complexities of the health care system.

NOTE:

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

Consumer Solutions and Self-Service Tools

Reminder Programs

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

- Mammograms for women.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

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

Decision Support

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

This program offers:

- Access to health care information.
- Support by a nurse to help you make more informed decisions in your treatment and care.
- Expectations of treatment.
- Information on providers and programs.

Conditions for which this program is available include:

- Back pain.
- Knee & hip replacement.
- Prostate disease.
- Prostate cancer.
- Benign uterine conditions.
- Breast cancer.
- Coronary disease.
- Bariatric surgery.

UnitedHealth Premium® Designation Program

To help people make more informed choices about their health care, the UnitedHealth Premium® designation program recognizes Network Physicians who meet criteria for quality and cost efficiency. UnitedHealthcare uses national standardized measures to evaluate quality. The cost efficiency criteria rely on local market benchmarks for the efficient use of resources in providing care.

For details on the UnitedHealth Premium® designation program including how to locate a *Premium Care Physician*, log onto **www.myuhc.com** or call the number on your ID card.

www.myuhc.com

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

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

- Research a health condition and treatment options to get ready for a discussion with your Physician.

- Search for Network providers available in your Plan through the online provider directory.
- Use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area.
- Use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

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

Visit www.myuhc.com and:

- Make real-time inquiries into the status and history of your claims.
- View eligibility and Plan Benefit information.
- View and print all of your Explanation of Benefits (EOBs) online.
- Order a new or replacement ID card or print a temporary ID card.

Want to learn more about a condition or treatment?

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

Disease Management Services

If you have been diagnosed with certain chronic medical conditions you may be eligible to participate in a disease management program at no additional cost to you. The heart failure, coronary artery disease, diabetes, asthma and Chronic Obstructive Pulmonary Disease (COPD) programs are designed to support you. This means that you will receive free educational information and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:

- Education about the specific disease and condition.
- Medication management and compliance.
- Reinforcement of on-line behavior modification program goals.
- Preparation and support for upcoming Physician visits.
- Review of psychosocial services and community resources.
- Caregiver status and in-home safety.
- Use of mail-order pharmacy and Network providers.

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

Complex Medical Conditions Programs and Services

Cancer Resource Services (CRS) Program

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

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

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

Congenital Heart Disease (CHD) Resource Services

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

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

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

program in order for the surgery to be considered a Covered Health Service under the Plan.

Kidney Disease Programs

Kidney Resource Services (KRS) program

End-Stage Renal Disease (ESRD)

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

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

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

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

Transplant Resource Services (TRS) Program

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

To learn more about Transplant Resource Services, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

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

Note: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card or visit www.myuhc.com for additional information.

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

What this section includes:

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

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

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

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

Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotherapy.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Autism Spectrum Disorder

Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental disability, developmental and learning disorders and behavioral training; for special training of physically or mentally disabled Participants where the special training furnished is primarily

in the nature of educational service, rather than in the nature of Medical Service; developmental delay services to include:

1. Behavior modification – Those behavioral or educational disorder services and associated expenses related to progress, staging or treatment of behavioral (conduct) problems, ADD, Oppositional Defiant Disorder, learning disabilities, developmental delays, mental disability, anoxic birth injuries, birth defects, cerebral Injury, non-Acute head Injuries or cerebral palsy;
2. Educational Services – Those educational services for remedial education including, but not limited to, evaluation or treatment of learning disabilities, minimal brain dysfunction, cerebral palsy, mental disability, developmental and learning disorders and behavioral training;
3. Treatment for disorders relating to learning, motor skills, and communication, and pervasive developmental conditions such as cerebral palsy and ADD, except as provided in the Covered Services section of this SPD;
4. Medical Services for the treatment of chronic brain Injury, including augmentative communication devices, developmental delay, mental disability or cerebral palsy are not Covered;

Dental

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

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

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

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

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

Endodontics, periodontal Surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
 - Extractions (including wisdom teeth), fillings restoration and replacement of teeth.
 - Medical or surgical treatments of dental conditions.
 - Services to improve dental clinical outcomes.

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

3. Dental implants, bone grafts and other implant-related procedures.
 - This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force requirement* or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.
6. Services and treatment for Temporomandibular Joint disorder (TMJ) and craniomandibular joint disorder.
7. Removal of dentiginous cysts, mandibular tori and odontoid cysts are excluded as they are dental in origin.
8. Services for overbite or underbite

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic Appliances that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*. This exclusion does not apply to cranial molding helmets and cranial banding.

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

3. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
4. Repairs to Prosthetic Devices due to misuse, malicious damage or gross neglect.

5. Replacement of Prosthetic Devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
6. Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME), Orthotics and Supplies* in Section 6, *Additional Coverage Details*.
7. Oral appliances for snoring (this exclusion does not apply to mandibular advancement devices).
8. Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Service.
9. Powered and non-powered exoskeleton devices.
10. Duplicate devices, appliances and prosthetics are not covered.
11. Upgrades are the responsibility of the Participant.

Drugs

1. Prescription drug products for outpatient use that are filled by a Prescription Order or Refill.
2. Self-Administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (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.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office. This exclusion does not apply to sublingual allergy drops.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy (covered under Prescription Drug plan).
6. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year.

This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one (1) year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a Calendar Year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a Calendar Year.
9. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
10. 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.
11. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.
12. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Experimental or Investigational or Unproven Services

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

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

Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses, except as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.
2. Nail trimming, nail cutting, or nail debridement, except as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

3. Medical or surgical treatment of onychomycosis (nail fungus).
4. Hygienic and preventive maintenance foot care. Examples include:

- Cleaning and soaking the feet.
- Applying skin creams in order to maintain skin tone.

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

5. Treatment of flat feet.
6. Treatment of subluxation of the foot.
7. Shoes except as described in Section 6, *Additional Coverage Details*.
8. Shoe orthotics, except as described in Section 6, *Additional Coverage Details*.
9. Shoe inserts.
10. Arch supports.

Implants and Related Medical Services

1. There is no Coverage for either penile or Nanometric implants, except as described in Section 6, *Additional Coverage Details*.
2. Implants for the treatment of sexual dysfunction or gender identity, except as described in Section 6, *Additional Coverage Details*.
3. No Coverage is provided for repair, replacement or duplicates nor is Coverage provided for Medical Services related to the repair or replacement of Covered implants, except when necessitated due to a change in the Participant's medical condition.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples include:
 - Ace bandages.
 - Gauze and dressings, except elastic supports after the initial placement and finger splints.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment in Section 6, Additional Coverage Details*.
- Diabetic supplies for which Benefits are provided as described under *Diabetes Services in Section 6, Additional Coverage Details*.

- Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies in Section 6, Additional Coverage Details*.
 - Urinary catheters for which Benefits are provided as described under *Urinary Catheters in Section 6, Additional Coverage Details*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment in Section 6, Additional Coverage Details*.

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

In addition to all other exclusions listed in this Section 8, *Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorder - Autism Spectrum Disorder* and/or *Substance-Related and Addictive Disorders Services in Section 6, Additional Coverage Details*.

1. 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*.
2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder, and paraphilic disorders.
4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition for or services that are school based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living Services (including recovery residences).
8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.
9. Residential care, for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Individual and group nutritional counseling, including non-specific disease 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 nutritional counseling services that are billed as *Preventive Care Services* or to 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 component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.
3. Appetite suppressants and supplies of similar nature
4. Food of any kind. Foods that are not covered include:
 - Infant formula, standard milk-based formula and donor breast milk. This exclusion does not apply to specialized enteral formula for which Benefits are provided as described under *Enteral Nutrition* in Section 6, *Additional Coverage Details*.
 - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
 - Oral vitamins and minerals.
 - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
 - Other dietary and electrolyte supplements.
5. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidentals for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters, duct cleaning and dehumidifiers.
 - Batteries and battery chargers, this exclusion does not apply to wheelchair batteries or portable oxygen systems.
 - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.

- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
- Electronic Communication Devices.
- Exercise equipment and treadmills.
- Food Blenders.
- Hot and cold compresses.
- Hot tubs.
- Humidifiers.
- Hypo-allergenic pillows.
- Jacuzzis.
- Medical alert systems.
- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Water purifiers.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 13, *Glossary*. Examples include:
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to

liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

- Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Sclerotherapy treatment of veins.
 - Hair removal or replacement by any means.
 - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Skin abrasion procedures performed as a treatment for acne.
 - Treatments for hair loss.
 - Varicose vein treatment of the lower extremities, when it is considered cosmetic.
2. Replacement of an existing intact 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 initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.
 3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, health club memberships and programs, spa treatments and diversion or general motivation.
 4. Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for Morbid Obesity.
 5. Wigs and other scalp hair prosthesis except for loss of hair resulting from Sickness or Injury.

Procedures and Treatments

1. Biofeedback.
2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
4. Speech therapy to treat stuttering, stammering, or other articulation disorders.
5. Speech therapy, except when required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism

Spectrum Disorder as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*.

6. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
7. Psychosurgery (lobotomy).
8. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include Health Care Providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
9. Chelation therapy, except to treat heavy metal poisoning.
10. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
11. For Gender Dysphoria, Cosmetic Procedures, including the following:
 - Abdominoplasty.
 - Blepharoplasty.
 - Body contouring, such as lipoplasty.
 - Brow lift.
 - Calf implants.
 - Cheek, chin, and nose implants.
 - Injection of fillers or neurotoxins.
 - Face lift, forehead lift or neck tightening.
 - Facial bone remodeling for facial feminizations.
 - Hair removal, except as part of a genital reconstruction procedure by a Physician for the treatment of Gender Dysphoria.
 - Hair transplantation.
 - Lip augmentation.
 - Lip reduction.
 - Liposuction.
 - Mastopexy.
 - Pectoral implants for chest masculinization.

- Rhinoplasty.
 - Skin resurfacing.
12. The following treatments for obesity:
- Non-surgical treatment of obesity, even if for Morbid Obesity.
 - Surgical treatment of obesity unless there is a diagnosis of Morbid Obesity as described under Obesity Surgery in Section 6, Additional Coverage Details.
13. Medical and surgical treatment of excessive sweating (hyperhidrosis).
14. Services for the treatment of Temporomandibular Joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
15. Upper and lower jawbone Surgery, orthognathic Surgery and jaw alignment.
- This exclusion does not apply to reconstructive jaw Surgery when there is a facial skeletal abnormality and associated functional medical impairment.
16. Breast reduction Surgery that is determined to be a Cosmetic Procedure.
- This exclusion does not apply to breast reduction Surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*. Coverage is provided for Medically Necessary breast reduction, including for male gynecomastia, and augmentation mammoplasty or if it is associated with Reconstructive Surgery following a Medically Necessary mastectomy.
17. Intracellular micronutrient testing.
18. Cellular and Gene Therapy services not received from a Designated Provider.
19. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your spouse, brother, sister, parent or child. This includes any service the provider may perform on themselves.
2. Services performed by a provider with your same legal residence.
3. Services or supplies for which you have no financial liability or that were provided at no charge
4. Medical services for which the Participant has no legal obligation to pay or for which a charge would not ordinarily be made in the absence of Coverage under the Benefit Plan.

5. Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or Facility for the service.
6. Services performed by an unlicensed provider or a provider who is operating outside of the scope of their license.
7. Services provided at a free-standing or Hospital-based diagnostic Facility without an order written by a Physician or other provider. Services that 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.
 - Is not actively involved in your medical care after the service is received.This exclusion does not apply to mammography.
8. Services ordered or delivered by a Christian Science Practitioner.

Rehabilitative Services

1. Rehabilitative services provided for long-term, Chronic Medical Conditions.
2. Rehabilitative services whose primary goal is to maintain the Participant's current level of function, as opposed to improving the functional status.
3. Educational or vocational therapy, schools or services designed to retrain the Participant for employment.
4. Rehabilitative services whose purpose is to treat or improve a developmental/learning disability or delay, cerebral palsy or congenital anomalies unless required by law.
5. Rehabilitation services that are Experimental or have not been shown to be clinically effective for the medical condition being treated.
6. Alternative rehabilitation services (e.g., massage therapy).
7. Fees or costs associated with services that are primarily exercise. Examples include, but are not limited to, membership fees for health clubs, fitness centers, weight loss centers or clinics or home exercise equipment.

Reproduction & Maternity Services

1. Health care services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
2. The following services related to a Gestational Carrier or Surrogate:
 - Fees for the use of a Gestational Carrier or Surrogate.
 - Insemination or InVitro fertilization procedures for Surrogate or transfer of an embryo to Gestational Carrier.
 - Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person.

3. Donor, Gestational Carrier or Surrogate administration, agency fees or compensation.
4. The following services related to donor services for donor sperm, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):
 - Known egg donor (altruistic donation i.e., friend, relative or acquaintance) - The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing or receiving a donated egg that is fresh, or one that has already been retrieved and is frozen.
 - Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. Medical costs related to donor stimulation and egg retrieval. This refers to purchasing a donor egg that has already been retrieved and is frozen or choosing a donor who will then undergo an egg retrieval once they have been selected in the database.
 - Known donor sperm (altruistic donation i.e., friend, relative or acquaintance) – The cost of sperm collection, cryopreservation and storage. This refers to purchasing or receiving donated sperm that is fresh, or that has already been obtained and is frozen.
 - Purchased donor sperm (i.e., clinic or sperm bank) – The cost of procurement and storage of donor sperm. This refers to purchasing donor sperm that has already been obtained and is frozen or choosing a donor from a database.
5. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
6. The reversal of voluntary sterilization.
7. Health care services and related expenses for surgical, non-surgical or drug-induced Pregnancy termination unless the life of the mother would be endangered if the fetus were carried to term. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy or missed abortion (commonly known as a miscarriage).
8. InVitro fertilization regardless of the reason for treatment.
9. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.
10. Newborn Home Delivery.
11. Non-Emergency services provided outside the Service Area, including elective care, obstetrical services after thirty-seven (37) weeks of Pregnancy, follow-up care of a Sickness or Injury, or care required as a result of circumstances that could have been reasonably foreseen by You before leaving the Service Area.

Services Provided under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*.
2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you.

3. While on active military duty.
4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

Transplants

1. Health services for transplants involving animal organs.
2. Health services for organ and tissue transplants except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
3. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.) Transplant services, screening tests, and any related conditions or complications related to organ donation when a Participant is donating an organ or tissue to a non-Covered individual.

Travel

1. Health services provided in a foreign country, that would otherwise not be covered within continental United States.
2. Travel or transportation expenses, even if ordered by a Physician. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care or maintenance care as defined in Section 13, *Glossary* or maintenance care.
2. Domiciliary Care, as defined in Section 13, *Glossary*.
3. Multi-disciplinary pain management programs provided on an inpatient basis for Acute pain or for exacerbation of chronic pain.
4. Private Duty Nursing received on an inpatient basis.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated Hospice Care program of services provided to a Terminally Ill person by a licensed Hospice Care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*.
6. Rest cures.
7. Services of personal care attendants.

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

Vision

1. Routine vision examinations, including refraction to detect vision impairment, received from health care provider in the provider's office. Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

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

2. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
3. Purchase cost and associated fitting charges for eyeglasses or contact lenses.
4. Eye exercise or vision therapy.
5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye Surgery and radial keratotomy and blepharoplasty.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.
2. Behavior modification - those behavioral or educational disorder services and associated expenses related to confirmation of diagnosis, progress, staging or treatment of behavioral (conduct) problems, ADD, Oppositional Defiant Disorder, learning disabilities, non-pervasive developmental delays, mental disability, anoxic birth Injuries, birth defects, cerebral Injury, non-Acute head Injuries or cerebral palsy; special training of physically or mentally disabled Participants where the special training furnished is primarily in the nature of educational service, rather than in the nature of Medical Service;
3. Cardiac Rehabilitation Care, Phase III.
4. Charges for:
 - Missed appointments.
 - Room or Facility reservations.
 - Completion of claim forms.
 - Record processing.
 - Telephone consultations.
 - Late payments.

- Medical services exceeding the Reasonable and Customary Charges for the services.
 - Services, care or treatment incurred before coverage begins and/or after coverage ceased under this Plan.
5. Charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
 6. Charges prohibited by federal anti-kickback or self-referral statutes.
 7. Counseling - relationship, marriage, academic and other counseling when not attributable to a mental disorder.
 8. Dermatological Services - Removal of benign pigmented nevi, sebaceous cysts and seborrheic keratosis (skin tags) that cause no functional impairment.
 9. Diagnostic tests that are:
 - Delivered in other than a Physician's office or health care Facility.
 - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.
 10. Expenses for health services and supplies:
 - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
 - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
 - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan.
 - That exceed Eligible Expenses or any specified limitation in this SPD.
 11. In the event a non-Network provider waives, does not pursue, or fails to collect, Copayments, Coinsurance and/or any deductible or other amount owed for a particular health care service, no Benefits are provided for the health care service when the Copayments, Coinsurance and/or deductible are waived, not pursued, or not collected.
 12. Foreign language and sign language services.
 13. Long-term (more than thirty (30) days) storage of blood, umbilical cord or other material.
 14. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 13, *Glossary*. Covered Health Services are those health

services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 6, Additional Coverage Details and in Section 5, Plan Highlights.
- Not otherwise excluded in this SPD under this Section 8, Exclusions.

15. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

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

16. Elective, not medically necessary surgical procedures.
17. Growth Hormone - Growth hormone therapy is only Covered under the Prescription Drug Benefit.
18. Non-Prescription Drugs - Over-the-counter drugs and medications incidental to Outpatient Care and Urgent Care Services are excluded, except as specifically listed in the Prescription Drug Program section of this SPD. Take-home drugs and medications resulting from an Emergency visit or Hospital stay are Covered. For more information, see the Express Scripts Prescription Drug Benefit Plan at the end of this Plan.
19. Treatment for disorders relating to learning, motor skills and communication.
20. Surgery performed solely to address physiological or emotional factors.
21. Nanometrics.
22. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
- Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; living outside the continental United States or as a result of incarceration.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
 - Related to judicial or administrative proceedings or orders.
 - Required to obtain or maintain a license of any type.

23. Health care services from a Non-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Residential Treatment Facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year.

This exclusion does not apply in the case of an Emergency or when there is no Network provider who is reasonably accessible or available to provide Covered Health Services.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

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

Network Benefits

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

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

Non-Network Benefits

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

If Your Provider Does Not File Your Claim

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

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

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

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

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

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

Payment of Benefits

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

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

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

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

Any such payment to a provider:

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

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

recovery rights to the Plan), pursuant to *Refund of Overpayments* in *Section 10: Coordination of Benefits*.

Eligible Expenses due to a non-Network provider for Covered Health Services that are subject to the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)* are paid directly to the provider.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that UnitedHealthcare in its discretion determines to be adequate.

Health Statements

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

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

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com. See Section 13, *Glossary*, for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

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

Claim Denials and Appeals

If Your Claim is Denied

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

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your Authorized Representative must submit your Appeal in writing within one hundred eighty (180) days of receiving the Adverse Benefit Determination. You do not need to submit Urgent Care Appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card.
- The provider's name.
- The date of Medical Service.
- The reason you disagree with the denial.
- Any documentation or other written information to support your request.

You or your Authorized Representative may send a written request for an Appeal to:

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

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

The Plan, at its own expense, shall have the right to require a Participant whose Sickness or Injury is the basis of a claim under this Summary Plan Description be examined by a Network Provider or other Health Care Provider of the Plan's choosing, when and as often, as the Plan may reasonably require while the claim is pending.

Types of claims

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

- Urgent care request for Benefits.
- Pre-service request for Benefits.
- Post-service claim.
- Concurrent claim.

Review of an Appeal

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

- An appropriate individual(s) who did not make the initial benefit determination.

- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

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

Filing a Second Appeal

Your Plan offers two levels of Appeal. If you are not satisfied with the first level Appeal decision, you have the right to request a second level Appeal from The University within sixty (60) days from receipt of the first level Appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or Appeals and submit opinions and comments. The University will review all claims in accordance with the rules established by the *U.S. Department of Labor*.

External Review Program

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

If one of the above conditions is met, you may request an external review of Adverse Benefit Determinations based upon any of the following:

- Clinical reasons.
- The exclusions for Experimental or Investigational Service(s) or Unproven Service(s).
- 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 set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received the University's decision.

An external review request should include all of the following:

- A specific request for an external review.
- The Covered Person's name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.

- Any new, relevant information that was not provided during the internal Appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three (3) or more IROs 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 is comprised of all of the following:

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

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

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

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

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

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

- All relevant medical records.
- All other documents relied upon by the University.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not

previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

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

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

Expedited External Review

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

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

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

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

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

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

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

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

Timing of Appeals Determinations

Separate schedules apply to the timing of claims Appeals, depending on the type of claim. There are three (3) types of claims:

- Urgent care request for Benefits - a request for Benefits provided in connection with Urgent Care services.
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided.
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

Please note that the 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 UnitedHealthcare are required to follow.

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

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

Pre-Service Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	5 days
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	15 days
You must then provide completed request for Benefits information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
<ul style="list-style-type: none"> if the initial request for Benefits is complete, within: 	15 days
<ul style="list-style-type: none"> 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

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UnitedHealthcare must notify you of the first level appeal decision within:	15 days after receiving the first level Appeal
You must appeal the first level Appeal (file a second level Appeal) within:	60 days after receiving the first level Appeal decision
The University must notify you of the second level Appeal decision within:	15 days after receiving the second level Appeal

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

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
<ul style="list-style-type: none"> if the initial claim is complete, within: 	30 days
<ul style="list-style-type: none"> 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
UnitedHealthcare must notify you of the first level Appeal decision within:	30 days after receiving the first level Appeal
You must appeal the first level Appeal (file a second level Appeal) within:	60 days after receiving the first level Appeal decision
The University must notify you of the second level Appeal decision within:	30 days after receiving the second level Appeal

Limitation of Action

You cannot bring any legal action against the University or the Claims Administrator to recover reimbursement until ninety (90) days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim, including an initial claim, first-level Appeal, second-level Appeal and external review have been

completed. If you want to bring a legal action against the University or the Claims Administrator, you must do so within three (3) years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the University or the Claims Administrator.

You cannot bring any legal action against the University or the Claims Administrator for any other reason unless you first complete all the steps in the Appeal process described in this section, including the first-level Appeal, second-level Appeal and external review. After completing that process, if you want to bring a legal action against the University or the Claims Administrator you must do so within three (3) years of the date you are notified of the final decision on your Appeal or you lose any rights to bring such an action against the University or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

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

When Does Coordination of Benefits Apply?

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

- A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- B. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
- C. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. **Non-Dependent or Dependent.** The Plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or

health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

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

- a) The Plan covering the Custodial Parent.
- b) The Plan covering the Custodial Parent's spouse.
- c) The Plan covering the non-Custodial Parent.
- d) The Plan covering the non-Custodial Parent's spouse.

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

- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph 2(a) or 2(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 2(a) to the dependent child's parent(s) and the dependent's spouse.

- 3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.
- 4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Plan that covered the person the longer period of time is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

How Are Benefits Paid When This Plan is Secondary?

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

- The Plan determines the amount it would have paid based on the Allowable expense.
- The Plan pays the entire difference between the Allowable Expense and the amount paid by the Primary Plan, as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the Allowable Expense.

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

Determining the Allowable Expense If this Plan is Secondary

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

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

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

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

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

- Disabled individuals under age 65 with current employment status and their Dependents under age 65.

Determining the Allowable Expense When this Plan is Secondary to Medicare

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

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

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

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator will use Medicare's Allowable Expense or Medicare's limiting charge for covered services as the Allowable Expense for both the Plan and Medicare.

Medicare Crossover Program

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

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

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

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

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

Right to Receive and Release Needed Information?

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

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

Does This Plan Have the Right of Recovery?

Overpayment and Underpayment of Benefits

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

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

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

Refund of Overpayments

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

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

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

If the refund is due from you and you do not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for you that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are

payable in connection with services provided to other Covered Persons under the Plan. The reallocated payment amount will either:

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

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

SECTION 11 - WHEN COVERAGE ENDS

What this section includes:

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

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

Plan coverage will terminate and entitlement to Benefits will end for a Covered Person upon the first to occur of the following:

- the last day of the month in which:
 - the Covered Person ceases to meet the eligibility requirements described in *Eligibility* in Section 2, *Introduction*; or
 - UnitedHealthcare receives written notice from the University to end your coverage, or the date requested in the notice, if later; or
 - the Employee ceases work or is no longer an Employee as defined by this Plan (which is the day immediately preceding the Employee's termination date) or loss of Employee status;** or

Example

If you cease working for the University on January 31 (your termination date will be February 1), Plan participation will cease on January 31, which is the last day of the month in which you ceased working (even though your termination date is in February). However, if you cease working on February 1 (your termination date will be February 2), Plan participation will cease on the last day of February because you ceased working in February.

This same example applies if, because of a change in your employment with the University (e.g., a reduction in hours below the eligibility threshold) you are no longer an eligible Employee under this Plan.

- the end of the period for which required Contributions have been paid; or
- the date the Plan terminates.

**For the purposes of coverage under this Plan:

- if an Employee ceases work because of Sickness or Injury, employment shall be deemed to continue until terminated by the University, acting in accordance with principles which preclude individual selection;
 - Employees who meet the definition of Long Term Disability Recipient (Section 13, *Glossary*) will no longer be eligible to participate in this Plan, unless the individual meets the End-Stage Renal Disease requirements in *Eligibility* in Section 2, *Introduction*.
 - Coverage under this Plan for a totally disabled individual will cease on the later of (1) the last day of the month in which the Employee meets the definition of totally disabled under the University's Long Term Disability Plan; or (2) the last day of the month in which the individual submits their enrollment form to the University for enrollment in the University's Retiree and Disability Plan or The Curators of the University of Missouri Group Medicare Advantage PPO Plan. See Retiree and disability SPD's Section 2: *How to Enroll*.
 - Coverage for individuals with End-Stage Renal Disease will cease on the last day of the month in which the individual's thirty (30)-month coordination period ends.
- if an Employee ceases work, pursuant to a leave of absence granted in the usual course of the University's business, employment shall be deemed to continue during such leave or leaves of absence.
- if an Employee suspends coverage while on an approved leave of absence, upon return from leave and within thirty-one (31) days, the Employee can resume enrollment, in accordance with the participation provisions in Section 2, *When Coverage Begins*, in the Plan in which the Employee was enrolled at the beginning of the leave of absence;
- if an Employee ceases work and is eligible to enroll in The Curators of the University of Missouri Group Medicare Advantage PPO Plan (because the Employee is a Medicare eligible "Retiree" or "LTD Recipient" as defined by that plan), coverage under this Plan will terminate on the earliest of the following:
 - the day immediately preceding the effective date of coverage under The Curators of the University of Missouri Group Medicare Advantage PPO Plan; or
 - the last day of the month that is thirty-one (31) days after the Employee's termination date.

A Dependent will cease to be eligible for the Plan on the earlier of the date the Employee's eligibility terminates or the last day of the month your Dependent no longer meets the requirements of Dependent status.

Other Events Ending Your Coverage

Coverage may be rescinded if you commit an act, practice, or omission that constitutes fraud, or make an intentional misrepresentation of material fact with respect to coverage

under this Plan, including, but not limited to, knowingly providing incorrect information relating to another person's eligibility or dependent status or failing to timely provide required documentation evidencing proof of relationship or loss of coverage (if applicable) (see Section 2, *Eligibility* for more information). The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice. The Plan will provide thirty (30) days advance written notice to each affected individual before coverage is rescinded.

For the purpose of this Plan, rescinded means a retroactive cancellation or discontinuance of coverage of Benefits provided under this Plan, but does not include a cancellation or discontinuance of coverage if:

- the cancellation or discontinuance of coverage has only a prospective effect; or
- the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required Contributions towards the cost of coverage.

Note: If UnitedHealthcare or the University find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact (which includes failure to timely provide required documentation evidencing proof of relationship or loss of coverage), the University has the right to demand that you pay back all Benefits the University paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

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

- The Child is incapable of self-sustaining employment due to a mental or physical disability prior to reaching the maximum age; and
- The Child receives Principal Financial Support from you or your Spouse; and
- You provide application for continuation of Dependent status for such a Child and proof of the Child's incapacity and dependency to the University within thirty-one (31) days of the date coverage would have otherwise ended because the child reached the maximum age, or in the case of a newly benefit-eligible employee, within thirty-one (31) days of becoming newly eligible; and
- You provide proof, upon the University's request, that the Child continues to meet these conditions.

To be eligible for continuation of Dependent status once the Child has reached the maximum age, the Child must be covered as a Dependent as defined in this Plan on the day immediately preceding the day the Child reaches the maximum age. If you fail to submit proof, coverage shall be discontinued at the end of the month in which the Dependent attains maximum age. In the case of a newly benefit-eligible employee, if application for Dependent status for such a Child and proof of the Child's status is not submitted within

thirty-one (31) days of the Employee adding the Child to their plan, the Dependent will not be eligible for coverage.

The University has the right to require proof of the continuation of disability upon attainment of such age as often as deemed necessary; however, you will not be asked to provide proof more than once a year. Proof includes:

- Social Security Benefit Verification Letter; or
- Completion of Physician Certification Form.

If you do not supply such proof within thirty-one (31) days of being requested, the Plan will no longer pay Benefits for that Child. The University reserves the right to request a medical examination at the University's expense.

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

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 13, *Glossary*.

Continuation Coverage under Federal Law (COBRA)

Federal law requires the Plan to offer Covered Employees and Dependents the opportunity to continue medical Coverage when it ends for certain specified reasons. This law is called the Consolidated Omnibus Budget Reconciliation Act of 1985 - COBRA. The following provisions outline the requirements for continued medical Coverage in accordance with the law. These provisions apply only to the extent that the required period of continued medical Coverage has not already been provided under other Plan provisions.

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.
- The University's Plan recognizes Sponsored Adult Dependent's as "Non-Qualified" Beneficiaries for purposes of the Plan, but they are covered for purposes of COBRA.
- These periods of continued medical Coverage begin on the date of loss of Coverage following the qualifying event; for instance, the first of the month following the date you leave the University or the date a Dependent becomes ineligible.

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/Sponsored Adult Dependent	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
You become entitled to Medicare	N/A	See table below	See table below
The University files for bankruptcy under Title 11, United States Code.	36 months	36 months ²	36 months ²

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of sixty (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 eighteen (18) months; (ii) the Qualified Beneficiary must agree to pay any increase in the required Contribution for the additional eleven (11) months over the original eighteen (18) months; and (iii) if the Qualified Beneficiary entitled to the eleven (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 eleven (11) months continuation of coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within thirty (30) days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than thirty (30) days after the date of that determination.

²From the date of the Participant's death if the Participant dies during the continuation coverage.

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 eighteen (18)-month period expires	36 months
You experience a qualifying event,* after which you become entitled to Medicare before the initial eighteen (18)-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

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

Getting Started

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

You will have up to sixty (60) days from the date you receive notification or sixty (60) days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional forty-five (45) days from the date you signed the election form to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

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

Continued Coverage will be exactly the same medical Coverage you or your Dependent would have been entitled to if your employment or their Dependent status had not changed. Any future changes in the Benefits or cost of Coverage for the Plan also will apply to you. A Dependent Child you acquire as an Employee Actively at Work while Covered by these provisions will also be entitled to continue medical Coverage.

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

- During Annual Enrollment.
- Following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the COBRA Administrator within sixty (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 COBRA Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the COBRA Administrator of these events within the sixty-day (60-day) period, the Qualified Beneficiary's rights to continued medical Coverage will be forfeited. If you are continuing coverage under federal law, you must notify the COBRA Administrator within sixty (60) days of the birth or adoption of a Child.

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

Divorced or widowed Spouses or Sponsored Adult Dependent at least age 55

Medical Coverage can continue beyond the COBRA period if the Continuation Coverage under the Plan expires when a divorced or widowed Spouse or Sponsored Adult Dependent is at least age 55. Coverage can continue for the Spouse, Sponsored Adult Dependent and eligible Dependents until the Spouse or Sponsored Adult Dependent reaches age 65 or becomes Medicare eligible due to disability, whichever occurs earlier.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond eighteen (18) months because you are eligible for disability benefits from Social Security, you must provide the HR Service Center or your HR Generalist with notice of the Social Security Administration's determination within sixty (60) days after you receive that determination, and before the end of your initial eighteen-month (18-month) continuation period. The maximum coverage for a disabled individual will be twenty-nine (29) months.

The notice requirements will be satisfied by providing written notice to the COBRA Administrator at the address stated in Section 14, *Important Administrative Information*. The

contents of the notice must be such that the COBRA 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.

The disabled individual is required to notify the University within thirty-one (31) days after any final determination by the Social Security Administration that the individual is no longer disabled.

Trade Act of 2002

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

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, they should contact the COBRA Administrator for additional information. The Participant must contact the COBRA Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose their 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 Contribution (for example: Contribution is not paid within forty-five (45) days);
- the date coverage ends for failure to make any other monthly Contribution (for example: Contribution is not paid within thirty (30) days of its due date);
- the date the entire Plan ends; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

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

Uniformed Services Employment and Reemployment Rights Act

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

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

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

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

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

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

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

Continued Medical Coverage During a Leave of Absence – Employees Actively at Work

Your medical Coverage may be continued while you are on a leave of absence, protected by the Family and Medical Leave Act of 1993 (FMLA), provided you continue to pay any required Contributions. If your Contributions are more than thirty-one (31) days late, your Coverage under the Plan will end, however, upon your return to work from a leave approved under the FMLA, you will be entitled to have your medical Coverage reinstated. If you fail to

return to work following the leave, you may be required to pay back the University for the cost of providing medical Coverage during your leave, however, you will not be required to repay the University if the reason you failed to return is due to a serious health condition or other circumstance beyond your control, as provided by law.

Your medical Coverage may be continued during a leave of absence for other reasons, according to University policy. Contact the HR Service Center or your HR Generalist for more information.

Continuation of Medical Coverage for Dependents After the Death of an Employee

If you die while actively employed by the University, your eligible Spouse may continue medical Coverage after your death under the Plan available to Retirees if the following requirements are satisfied:

- Your Spouse must have been married to you at the time of your death, and you must have been married to such Spouse for at least one (1) year preceding your death; and
- Either:
 - At the time of your death, you must have been vested in the University of Missouri Retirement, Disability and Death Benefit Plan (having completed at least five years (5) of creditable service), or you would have been vested if you were Covered by the University of Missouri Retirement, Disability and Death Benefit Plan instead of the Civil Service plan, Federal Employee Retirement plan or the Missouri State Retirement plan; or
 - effective January 1, 2020, at the time of your death, you must have been a benefit eligible employee for the five (5) consecutive years immediately preceding your death.

Alternatively, your Sponsored Adult Dependent is eligible to continue medical Coverage after your death if the above conditions are satisfied, except that in lieu of the marriage requirements above, you must have provided a Sponsored Adult Dependent affidavit to the University at least one (1) year preceding your death.

In addition, the continuation of medical Coverage is available for your Children, but only when Spouse Coverage is also continued. The continuation of medical Coverage under this provision is subject to the payment of monthly Contributions by your Spouse. Eligible Children are described in Section 13, *Glossary*.

No continued medical Coverage is available for Children unless there is a Surviving Spouse or Surviving Sponsored Adult Dependent who is also Covered. Refer to the COBRA section for information on continuation of Coverage for Dependent Children, upon Employee's death, when no Surviving Spouse or Surviving Sponsored Adult Dependent is Covered.

Enrollment for continued medical Coverage must be made within thirty-one (31) days after the Employee's death.

Continued medical Coverage will terminate for any Dependent on the earliest of the following dates:

- The date the individual no longer meets this Plan's definition of an eligible Dependent.
- The date all Dependent Coverage is discontinued under this Plan with respect to your class of Employees.
- The end of the period for which the required Contributions have been made.

SECTION 12 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent Children.
- Your relationship with UnitedHealthcare and the University.
- Relationships with providers.
- Interpretation of Benefits.
- Information and records.
- Incentives to providers and you.
- The future of the Plan.

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 University 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, effective the first day of the month following the date the QMCSO was received by the University. If you are not enrolled in the Plan, the University shall enroll you as the same Effective Date as your Dependent, and you shall be responsible for any required Employee Contributions.

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

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

Your Relationship with UnitedHealthcare and the University

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

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care you may receive (the Plan pays for Covered Health 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.

The University and UnitedHealthcare may use individually identifiable information about you to identify for You (and You alone) procedures, products or services you may find valuable. The University and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. The University and UnitedHealthcare may 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 the University 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.

The University and the Claims Administrator do not provide health care services or supplies, nor do they practice medicine. Instead, the University and the Claims Administrator arrange for health care providers to participate in a Network and administer payment of Benefits. Network Providers are independent practitioners who run their own offices and facilities. The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials but does not assure the quality of the services provided. They are not the Plan's employees nor are they employees of the Claims Administrator. The Plan and the Claims Administrator are not responsible for any act or omission of any provider.

The Claims Administrator is not considered to be an employer of the University for any purpose with respect to the administration or provision of Benefits under this Plan.

The University 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 the service fee to the Claims Administrator.
- The funding of Benefits on a timely basis.
- Notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

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

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses.

- Are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- Must decide if any provider treating you is right for you (this includes Network Providers you choose and providers to whom you have been referred).
- Must decide with your provider what care you should receive.

Interpretation of Benefits

The University and UnitedHealthcare have the sole and exclusive discretion to:

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

The University and UnitedHealthcare may delegate this discretionary authority to other persons or entities including UnitedHealthcare's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and UnitedHealthcare's discretion. In order to receive Benefits, you must cooperate with those service providers.

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

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

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

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcare's reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in

UnitedHealthcare's Network through UnitedHealthcare's provider website. Network Physicians and providers are prohibited from billing you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcare's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UnitedHealthcare's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to **www.myuhc.com** or by calling the telephone number on your ID card.

UnitedHealthcare 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 Services. The methodology is usually based on elements reflecting the patient complexity, direct costs, and indirect costs of an Emergency Health Service. If the methodology(ies) currently in use become no longer available, UnitedHealthcare will use a comparable methodology(ies). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable methodology.

Information and Records

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

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

The University and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as the University is required to do by law or regulation. During and after the term of the Plan, The University and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements The University recommends that you contact your Health Care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

In some cases, the University and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the University.

Incentives to Providers

Network Providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- 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 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 Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network Providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in Section 5, *Plan Highlights*.

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

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount

programs, administrative programs, and/or programs to seek care in a more cost effective setting and/or from Designated Providers. In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours, in consultation with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on your ID card if you have any questions.

Rebates and Other Payments

The University and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The University and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

Workers' Compensation Not Affected

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

Future of the Plan

Although the University expects to continue the Plan indefinitely, it reserves the right to terminate, suspend, discontinue or amend the Plan in whole or in part, at any time and for any reason, at its sole determination.

Changes in the Plan may occur in any or all parts of the Plan including Benefit Coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, eligibility and the like. The Plan shall be construed and administered to comply in all respects with applicable federal law. Amendments are binding on all Employees and Dependents (including those Participants on Continuation Coverage).

An Amendment to this Plan may be made retroactively effective but will not adversely affect the rights of a Participant under this Plan for Covered Charges provided after the Effective Date of the Amendment but the before the Amendment is adopted.

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

Trust Fund

The Fund

- The Fund upon the books of the University designated as Medical Benefit Plan and all additions thereto is hereby set aside and dedicated as a Trust Fund to be held by the University in Trust so long as any Benefits payable under the Plan or any Amendments adopted thereto prior to its termination may be outstanding and may become payable. Such Trust Fund shall be used solely for the purpose of payment of such Benefits and not be subject to diversion for any other purpose so long as said Trust shall exist.
- All such money and such payments as shall from time to time be made to the Fund in accordance with the Plan or by direction of the Board and such earnings, profits, increments and accruals thereon as may occur from time to time and all money or property paid or delivered into the Fund by State appropriation or by others and all investments made therewith or proceeds thereof and all earnings and profits thereon, less the payments which at time of reference shall have been made by the Trustee as authorized herein shall constitute the Fund. The Fund shall be held by the University as Trustee and dealt with solely in accordance with the expressed provisions of this Plan.
- The Fund shall be the sole source of all medical Benefit payments or other Benefits provided under this Plan and in no circumstance shall any other Funds of the University, any member of the Board individually, Employees of the University, or any individuals who are members thereof, be liable or responsible.

Trustees

- It shall be the duty of the Trustee hereunder to hold, possess, manage and subject to the provisions of this Section hereof, to invest and to reinvest the Fund and to pay monies from the Fund as provided for in the Plan.
- The Trustee hereunder shall hold, possess, manage and control the property which from time to time constitutes the Fund by it hereunder, with full power and authority as follows:
 - To lease for any period, sell, exchange, transfer and convey any of the Trust property, real or personal, upon such terms and in such manner and for such prices or consideration as to it shall seem fit and proper; and no person dealing with the Trustee shall be bound to see to the application of the purchase money or to inquire into the validity, expediency, or propriety of any such sale or other disposition;
 - To invest and reinvest all and every part of the Trust estate in such manner and in such real estate, such stocks, common or preferred, bonds, debentures, mortgage notes, shares or participation in common Trust Funds (including any common Trust Fund or other special pooled Fund managed by the Trustee) or investment Trusts and other property, either personal or real, as to the Trustee shall seem desirable investments, having particularly in view the preservation of the Trust estate and the amount and regularity of the income to be derived therefrom and such investments and reinvestment shall not be restricted to securities or property of the character required for investment by Trustees or for the investment of Trust Funds under any present or any future laws;
 - To retain without liability for depreciation or loss any and all property, real or personal, tangible or intangible, which is delivered to and received by the Trustee

to be held by it pursuant to the terms hereof so long as the Trustee, in its discretion believes such property to be a desirable investment for this Trust;

- In its absolute discretion, to keep such portion of the Fund in cash or cash balances as it may deem advisable from time to time. Without limiting the generality of the foregoing, the Trustee shall keep such portion of the Fund in cash or cash balances as may be needed to meet contemplated benefit payments;
 - To commingle all or any part of the property at any time constituting the Fund with any other property held by it in Trust or for its own account for the purpose of investing to better advantage the property held hereunder;
 - To exercise all rights and privileges with relation to any securities at any time held as part of the Fund, including, but not by way of limitation, the right to carry the same in the registered name of a nominee of the Trustee and to exercise conversion, subscription and voting rights and to grant proxies, discretionary or otherwise;
 - To enforce any right, obligation, or claim in its absolute discretion, in general to protect in any way in the interests of the Fund, either before or after default and where it shall consider such action for the best interest of the Fund and in its absolute discretion of abstain from the enforcement of any right, obligation or claim;
 - From time to time to employ suitable agents, assistants and counsel and to pay their compensation from the Fund and to pay from the Fund all reasonable expenses incident to and arising out of the administration of the Fund, provided, however, no money shall ever be paid from the Fund to the Trustee as fees or compensation for any service rendered by it as Trustee in the control, management and administration of the Trust;
 - Notwithstanding any other provision hereof, to employ on behalf of the Trust one or more banks, Trust companies or other investment counsel as agent of the Trustee under an agency agreement providing that the bank, Trust company, or other investment counsel shall hold and have sole custody of and invest such of the Funds of the Trust placed under its care within the terms and conditions of the agency agreement, which agency agreement shall conform to the limitations of this Plan. Under any such agency agreement, the Trustee may delegate to the bank, Trust company or other investment counsel the power and responsibility for the selection, purchase and sale of securities for the Trust and such other powers and responsibilities imposed upon the Trustee hereunder, whether ministerial or discretionary, as the Trustee deems advisable or necessary, subject at all times to the full control and direction of the Trustee and the duty exercise of all such powers and responsibilities as may be required by the Trustee; and
 - To execute all documents and papers and do and perform all acts which it may deem necessary or proper in the exercise of any and all of the powers of the Trustee provided hereunder upon such terms and conditions as to it may seem for the best interest of the Fund.
- The Trustee shall not be liable for the making, retention, or sale of any investment or reinvestment made by it as herein provided or for any loss to or diminution of the Fund,

or for anything done or omitted to be done by it, except for its own negligence, willful misconduct or lack of good faith. The Trustee shall be fully protected in acting upon advice of competent counsel.

- As of June 30 of each year, the Trustee shall prepare a report of the status of the Fund, which report shall be presented to the Board and filed with the minutes of the meeting at which the report is presented. Such reports always shall be subject to inspection by any interested person at any reasonable time. Each such report shall contain the following information:
 - The present composition of the Fund with notations of changes therein since the date of the last report;
 - A description of all reinvestment made since the date of the last report;
 - An extension of the fair market value as of the date of the report of each item held in the Trust;
 - A statement of the amount and source of income received since the date of the last report; and
 - A statement of the distributions from the Fund since the date of the last report, giving the total amounts paid for medical Benefits payments, administrative fee payments and consulting fee payments.
 - Such other data and information as the Board may from time to time reasonably require.

Right to Amend Trust

- The Board may at any time and from time to time as otherwise provided in the Plan modify or amend, in whole or in part, any or all of the provisions of this Trust, provided that no such modification or Amendment shall divert the Fund or any part thereof from the purposes for which it is dedicated. It shall be impossible by operation of this Trust, by natural termination thereof, by power of revocation or Amendment, by the happening of any contingency, by collateral arrangement, or by any other means for any part of the Fund or the income therefrom to be used for or diverted to purposes other than for the exclusive benefit of the Participants of the Plan.
- In the event any provision of this Trust shall be held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining provisions of this Trust, but shall be fully severable and the Trust shall be construed and enforced as if said illegal or invalid provisions had never been inserted therein.

Medicare Eligibility

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

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

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If

you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 10, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

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

SECTION 13 - GLOSSARY

What this section includes:

Definitions of terms used throughout this SPD.

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

Abortion - the termination of Pregnancy before the fetus reaches the stage of viability. A Medically Necessary Abortion is the termination of Pregnancy when the Pregnancy jeopardizes the mothers' life. An Elective Abortion is the voluntary termination of Pregnancy for other than medical reasons as described in Medically Necessary Abortion.

Accident - a specific unforeseen sudden event occurring by chance resulting in bodily strain or trauma.

Actively at Work or Active Employment - an Employee is performing all of the essential functions of the job at the usual place of employment or at a place designated by the University. It shall also refer to any Employee on vacation or on leave of absence (if they worked at least one day prior to commencing leave) for any reason other than temporary layoff not at the Employee's regular place of employment. This definition will not act to defer Coverage for an Employee who is not Actively at Work due to a Health Factor.

Acute - a Sickness or Injury that is both severe and of recent onset.

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.

Adverse Benefit Determination - a denial of a request for service or a failure to provide or make payment in whole or in part for a Benefit. An Adverse Benefit Determination based in whole or in part on a medical judgment also includes;

- Any reduction or termination of a Benefit;
- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined to be not Medically Necessary or inappropriate;
- The failure to cover services because they are Cosmetic;
- The failure to cover services because they involve out of area referrals;
- The failure, reduction, or termination regarding the availability, delivery or quality of health care services;

- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services; and
- The failure, reduction, or termination regarding terms of the contractual relationship between a Participant and the Plan.

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR* (code of federal regulation) *414.605*.

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

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

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

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

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

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

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

Annual Enrollment - the period of time, determined by the University, during which eligible Participants may enroll or change Plans for themselves and their Dependents. The University determines the period of time that is the Annual Enrollment period. Enrollments during Annual Enrollment will be effective the following January 1.

Appeal - a request by You or Your Authorized Representative for consideration of an Adverse Benefit Determination of a Medical Service request or Benefit that You believe You are entitled to receive.

Applied Behavioral Analysis (ABA) - the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior.

Authorized Representative is an individual authorized by You or state law to act on Your behalf in obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent in emergent situations.

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 Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Birthing Center - any freestanding health Facility, professional office or institution which is not a Hospital or in a Hospital where births occur in a home-like atmosphere. This Facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the Facility is located.

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

Calendar Year - January 1st through December 31st of the same year.

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you by the University. The CRS program provides:

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

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

CHD - see Congenital Heart Disease (CHD).

Child or Children -

- natural Children; or
- stepchildren (note that the child of an Employee's Sponsored Adult Dependent is not a stepchild); or
- foster Children (subject to court order or placement by an authorized agency); or
- legally adopted Children or Children placed in the Employee's home for adoption (subject to court order); or
- each Child, who otherwise meets the definition of "Child" under the Plan, of an Employee for whom the University has received a valid Notice of Order to Enroll and for which the University is obligated to comply under Senate Bill No. 253 which repeals various Sections of RSMO 1986 and RSMO Supp. 1992; or
- each Child who a court has lawfully appointed the Employee (and/or the Employee's legal Spouse) as a legal guardian (legal guardianship) who is responsible for providing Principal Financial Support, provided the:
 - Child is unmarried
 - Child resides full-time with the Employee in parent-child relationship
 - Child is declared a dependent on the Employee's federal income tax return; and
 - legal guardianship was awarded prior to the child's 18th birthday and is still in effect.
 - Legal guardianship ends on the child's 18th birthday, unless there is a court order extending the guardianship.

Dependent Children must meet additional requirements, as specified in the definition of Dependent, in order to be eligible to participate in this Plan.

Chronic Medical Condition - a health condition that is continuous or persistent over an extended period of time (> 6 months) that:

- Requires periodic visits with a health care Provider, and
- May be associated with episodic rather than continuous periods of incapacity.

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

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

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

COBRA Administrator – ASI COBRA, LLC.

Coinsurance – the charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Confinement - an uninterrupted stay of at least twenty-four hours following formal admission to a Hospital, an Alternate Facility, or SNF.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first twelve (12) months of birth.

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

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during their Pregnancy.
- Have no known cause.

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

Contributions means the amount designated by the University from time to time as the amount of Contributions Employees and Qualified Beneficiaries are required to make in order to receive Benefits under this Plan. The University may change these amounts at its discretion subject to prior notification to the Participants. Employee Contributions may be provided through the University of Missouri Flexible Benefits Plan.

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

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and Prosthetic Devices.

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

- Medically Necessary.
- Described as a Covered Health Service in this SPD under Section 5, *Plan Highlights* and 6, *Additional Coverage Details*.
- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 8, *Exclusions*.

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.

CRS - see Cancer Resource Services (CRS).

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

Deductible - see Annual Deductible.

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

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

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

Designated Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Provider - a provider and/or Facility that:

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

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

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

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims

Administrator's behalf, to deliver Covered Health Care Services through live audio with video technology or audio only.

DME - see Durable Medical Equipment (DME).

Domestic Partnership- see Sponsored Adult Dependent Partnership.

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

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

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

Effective Date - the date of Coverage as determined by the Plan.

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

Eligible Expenses are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops the reimbursement policy guidelines, in its discretion, following evaluation and validation of all provider billings generally in accordance with one or more of the following methodologies:

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

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, which is both of the following:

- Arises suddenly.

- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.
- Refer to “Medical Emergency.”

Emergency Health Services – with respect to an Emergency:

- An appropriate medical screening examination (as required under section 1867 of the *Social Security Act*, 42 U.S.C. 1395dd or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section 1867 of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, “to stabilize” has the meaning as given such term in section 1867(e)(3) of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)).
- Emergency Health Services include items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items or services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
 - a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
 - b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
 - c. The patient is in such a condition, as determined by the Secretary, to receive information as stated in (b) above and to provide informed consent in accordance with applicable law.
 - d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
 - e. Any other conditions as specified by the Secretary.

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

Employer - The Curators of the University of Missouri.

EOB - see Explanation of Benefits (EOB).

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 and The University a determination regarding coverage in a particular case, are determined to be any of the following:

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

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one (1) year of the request for treatment, the Claims Administrator and The University may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and The University must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

- The Benefits provided (if any).
- The allowable reimbursement amounts.
- Deductibles.
- Coinsurance.

- Any other reductions taken.
- The net amount paid by the Plan.
- The reason(s) why the service or supply was not covered by the Plan.

Facility - a place for the treatment or diagnosis of a Sickness, Injury, or condition that is properly licensed by the appropriate state regulatory and licensing authorities, which facilities include Hospitals, Outpatient Emergency care centers, Ambulatory Surgical Centers, and other medical care facilities.

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

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

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

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.
- Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

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

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

Health Care Provider - any Physician, health care practitioner, Hospital, health care Facility, health care supplier or other Health Care Provider practicing or providing services/supplies within the scope of a valid license or other legal authority granted by the state where the Health Care Provider practices and whose treatments or services are Covered Charges

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

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

Hospice Care - those services and supplies provided through a Hospice agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed Facility and home care as detailed in Section 6, Additional Coverage Details.

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

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

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

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

Independent Freestanding Emergency Department – a health care facility that:

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

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

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

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

Inpatient Stay - an uninterrupted Confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours (3) per day, two (2) or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine (9) to nineteen (19) hours per week of structured programming for adults and six (6) to nineteen (19) hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

Intermittent Services - skilled nursing care that is provided or needed either:

- Fewer than seven (7) days each week.
- Fewer than eight (8) hours each day for periods of twenty-one (21) days or less.

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

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

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

Long Term Disability Recipient- an individual who while covered as an Employee (as defined in University Collected Rules and Regulations CRR 310.020 and CRR 320.050), became totally and permanently disabled in accordance with the University's Long Term Disability Plan and is entitled to continued service credit (ie. vested) as a disabled Employee under the University's Retirement, Disability and Death Benefit Plan, or, effective January 1, 2020, who has been a benefit eligible employee for the five (5) consecutive years immediately preceding the date on which the Employee became totally and permanently disabled.

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.

Marketplace is a competitive marketplace established under § 1311 of the Patient Protection and Affordable Care Act, commonly referred to as an Exchange or a Health Insurance Marketplace.

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 Emergency- the sudden and Acute onset of a medical condition manifesting itself by symptoms of sufficient severity (including pain) such as a prudent person, with an average

knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or their unborn Child, or
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.
- Some examples of a Medical Emergency include but are not limited to:
 - Broken bone;
 - Chest pain;
 - Seizures or convulsions;
 - Severe or unusual bleeding;
 - Severe burns;
 - Suspected poisoning;
 - Trouble breathing;
 - Vaginal bleeding during Pregnancy.

Medical Expense - the Covered Charges incurred by the Participant as the result of an Injury, Sickness, Preventive Care, or Surgical Procedure for Medically Necessary and Appropriate services, treatments, supplies, or drugs. Medical Expenses will be deemed to be incurred as of the date of the performance of the service or treatment, or the date of purchase of the supply or drug giving rise to the charge.

Medical Non-Emergency Service - care which can safely and adequately be provided other than in a Hospital.

Medical Services - the health care services and supplies Covered under the Benefit Plan, except to the extent that such health care services and supplies are limited or excluded under the Benefit Plan.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.

- Not mainly for your convenience or that of your doctor or other Health Care Provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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

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

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

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

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

Mental Health/Substance-Related and Addictive Disorders (MH/SUD)

Administrator - the organization or individual designated by the University who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Morbid Obesity - a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Participant.

Nanometrics - Nanometric-based therapeutics that are products that use ultra-small (Nanometric/ molecular-sized) electronic or mechanical devices.

Negotiated Rate - the amount which a Network Provider has agreed to accept as payment in full for a specified treatment, service or supply provided to a Plan Participant, pursuant to a contract between the applicable Network Provider and a Provider Network Service Contractor.

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

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

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network Providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Network Benefits and Section 3, *How the Plan Works*, for details about how Network Benefits apply.

Network Provider - a Provider who has entered into a direct or indirect written agreement with the Claims Administrator to provide Medical Services to Participants. The participation status of Providers may change from time to time.

Non-Network Benefits - for Benefit Plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network Providers. Refer to Section 5, *Plan Highlights* to determine whether or not your Benefit plan offers Non-Network Benefits and Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

Orthotic Appliances - Orthotic Appliances that correct a defect of a body form or function.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every Calendar Year. Refer to Section 5, *Plan Highlights* for

the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Outpatient - a Participant receiving medical care or treatment other than as an In-patient or shall refer to Medical Expenses other than those which are associated with a Hospital Confinement.

Outpatient Care and/or Services - treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray Facility, an Ambulatory Surgical Center or the patient's home.

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

Participant - a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States. References to "member" throughout this SPD are references to a Participant.

Participating Provider - a Provider who has entered into a direct or indirect written agreement with the Claims Administrator to provide Medical Services to Participants. The participation status of Providers may change from time to time.

Personal Health Support - programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription Pharmaceutical Products administered in connection with a Covered Health Service by a Physician or other Health Care Provider within the scope of the provider's license and not otherwise excluded under the Plan.

Phase II Cardiac Rehabilitation - cardiac rehabilitation administered on an outpatient basis immediately following hospitalization. Consists of 1) supervised exercise training to maximize functional capacity, teach safe exercise practices, and identify patients at risk for complications; 2) risk factor modification; and 3) education about medications, signs and symptoms of heart disease and its progression, dietary modifications and activity guidelines.

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

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, nurse practitioner, physician assistant, nurse midwife or other provider who acts within the scope of their license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - The Curators of the University of Missouri Medical Plan.

Plan Administrator - The Curators of the University of Missouri or its designee.

Plan Sponsor - The Curators of the University of Missouri.

Plan Year - the twelve (12)-month period ending each December 31.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with the above.

Premium - is the monthly fee required from the Employer on behalf of each Participant and each enrolled Dependent in accordance with the terms of the Benefit Plan.

Prescription Drugs - any medical substance for which the label is required by the Federal Food, Drug and Cosmetic Act to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription".

Prescription Order or Refill - the Authorization for a Prescription Drug issued by an Authorized Prescriber.

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

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

Principal Financial Support - an Employee, during the Calendar Year is continuously providing more than one half of the total support of a Child, including the amount spent to provide food, lodging, clothing, education, medical, dental and vision care, recreation, transportation and similar necessities.

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

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

- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or their family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

Prosthetic Devices - Prosthetic Devices that aid body functioning or replace a limb or body part.

Qualified Beneficiary - a Participant or a Covered Dependent of a Participant Covered under this Plan on the day prior to the qualifying event. To the extent required by law, Qualified Beneficiary will also mean a Child born to the Employee, or placed for adoption with the Employee, during a period of Continuation Coverage.

Qualified Medical Child Support Order (QMCSO) - 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.

Reasonable and Customary Charges - charges for Medical Services, treatments, supplies, or drugs essential to the care of the individual which are the lesser of:

- actual charges for such services, treatments, supplies, or drugs; or
- the amount normally charged for comparable services, treatments, supplies, or drugs by most Providers in the locality at the time incurred, where the charges were incurred when furnished to a similarly situated individual for a similar Sickness or Injury.

Recognized Amount – the amount which the Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the *Public Health Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the *Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the *Social Security Act*), an ambulatory surgical center as described in section 1833(i)(1)(A) of the *Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

- 1) An *All Payer Model Agreement* if adopted,

- 2) State law, or
- 3) The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include Surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify Surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician.

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician.
- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.

- Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Secretary of HHS – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260)*.

Self-Administered Injectables - Injectable Prescription Drugs commonly and customarily administered by the Covered Person. Examples of Self-Administered Injectables include but are not limited to the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain Injectable HIV drugs, certain osteoporosis agents, and heparin products. Self-Administered Injectables are obtained from a Specialty Pharmacy. The following are not considered Self-Administered Injectables because they are not obtained from a Specialty Pharmacy: insulin, glucagon, bee sting kits, Imitrex and Injectable contraceptives.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area in which the Provider Network Service Contractor has selected, established and maintains a contracted network of Health Care Providers.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

- They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
- A Physician orders them.
- They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- They require clinical training in order to be delivered safely and effectively.
- They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing Facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of their practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

Sponsored Adult Dependent - a person of the same or opposite sex with whom the Participant has a relationship and who meets all of the following criteria: established Sponsored Adult Dependent Partnership.

Sponsored Adult Dependent Partnership - also commonly known as Domestic Partnership, is a relationship between a Participant and one other person of the same or opposite sex who meets all of the following criteria:

- Has had a single dedicated relationship of at least twelve (12) months with the Employee.
- Has had the same principal residence as the Employee for at least twelve (12) months, and continues to have the same principal residence as the Employee disregarding temporary absences due to special circumstances including Sickness, education, business, vacation or military service;
- Is eighteen (18) years of age or older;
- Is not currently married to another person under either statutory or common law;
- Is not related to the Employee by blood or degree of closeness that would prohibit marriage in the law of the state in which the Employee resides, and
- Has not been determined by a court or physician to be mentally incompetent.

Spouse - the legal Spouse of an Employee, other than a deceased Employee, excluding a divorced Spouse or a Spouse separated by contract or decree from the Employee;

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean treatment of the disorder is a Covered Health Service.

Surgery or Surgical Procedure - a cutting operation, treatment for a fracture, reduction of a dislocation, endoscopic procedure, radiation therapy if used in lieu of a cutting operation for the purpose of removing a tumor, tonsils or excessive lymphoid tissue, injection treatment of hernia, hemorrhoids or varicose veins, and all substantially equivalent procedures.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a *CMS* defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Temporomandibular Joint (TMJ) syndrome - the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

Terminally Ill - having a life expectancy of six months or less as diagnosed by a Physician.

Therapeutic Donor Insemination (TDI) - Insemination with a donor sperm sample for the purpose of conceiving a child.

The University - The Curators of the University of Missouri, a public corporation, including all of its divisions, branches and parts.

Transitional Living- Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangement which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services – health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)

- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.myuhc.com**.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one (1) year of the request for treatment) the Claims Administrator and Plan Sponsor may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator and Plan Sponsor must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care - treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center - a Facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- Do not require an appointment.
- Are open outside of normal business hours, so you can get medical attention for minor Sicknesses that occur at night or on weekends.
- Provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

You/Your - a Participant Covered under this Plan.

SECTION 14 - IMPORTANT ADMINISTRATIVE INFORMATION

What this section includes:

- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by UnitedHealthcare Insurance Company. The named fiduciary of the Plan is the University, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's Network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and Surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (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 forty-eight (48)-hour (or ninety-six (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 forty-eight (48) hours (or ninety-six (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.

ATTACHMENT III - HEALTH SAVINGS ACCOUNT

What this attachment includes:

- About Health Savings Accounts.
- Who is eligible and how to enroll.
- Contributions.
- Additional medical expense coverage available with your Health Savings Account.
- Using the HSA for Non-Qualified Expenses.
- Rolling over funds in your HSA.

Introduction

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that you could establish to complement the Healthy Savings Plan (high deductible medical plan.) In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the high deductible health plan that is associated with the "HSA".

The University has entered into an agreement with United Healthcare Services, Inc., Minnetonka, MN, ("UnitedHealthcare") under which UnitedHealthcare will provide certain administrative services to the Plan.

UnitedHealthcare does not insure the Benefits described in this attachment. Further, note that it is the Plan's intention to comply with *Department of Labor* guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by the University. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the Healthy Savings Plan.

An HSA is an account funded by you, your Employer, or any other person on your behalf. The HSA can help you to cover, on a tax-free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses, however, these amounts are subject to income tax and may be subject to 20% penalty.

You have three tools you can use to meet your health care needs:

- The Healthy Savings Plan.
- An HSA you establish.
- Health information, tools and support.

What is an HSA?

An HSA is a tax-advantaged account Participants can use to pay for qualified health expenses they or their eligible Dependents incur, while covered under a high deductible medical plan. HSA Contributions:

- Accumulate over time with interest or investment earnings.
- Are portable after employment.
- Can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

Who Is Eligible And How To Enroll

You must be covered under a high deductible medical plan, the University's Healthy Savings Plan, in order to participate in the HSA. In addition, you:

- Must not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- Must not participate in a full health care Flexible Spending Account (FSA).
- Must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare).
- Must not be claimed as a dependent on another person's tax return.

Contributions

Contributions to your HSA can be made by you, by your Employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the Contributions reach the Contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further Contributions may be made to the HSA.

The Contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the maximum allowed by federal regulations. The current maximum Contributions can be found on the UM System Office of Human Resources website at <http://www.umsystem.edu/totalrewards/benefits/hsa>.

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

Note: Amounts that exceed the Contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess Contribution" prior to April 15th of the following year.

Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible Dependents' out-of-pocket costs under the medical plan, including Annual Deductibles and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the Medical Expenses of you and your eligible Dependents, meaning your Spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

Additional Medical Expense Coverage Available with Your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional Medical Services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

Using the HSA for Non-Qualified Expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA

to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA contributions and Medicare contributions.

Rollover Feature

If you do not use all of the funds in your HSA during the Calendar Year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in your medical plan SPD. You will however be required to pay the monthly maintenance fee on the HSA account.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA contributions while COBRA coverage is in effect.

Important

Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. The University and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. The University and the Claims Administrator are not responsible or liable for the misuse by Participants of HSA funds by, or for the use by Participants of HSA funds for non-qualified health expenses.

Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify the Claims Administrator and the financial institution in writing.

You can obtain additional information on your HSA online at www.irs.gov. You may also contact your tax advisor. Please note that additional rules may apply to a Dependent's intent to opening an HSA.

ATTACHMENT IV – PRIVACY AND CONFIDENTIALITY OF HEALTH-RELATED INFORMATION

Definitions

All terms not specifically defined in this Section shall have the meaning ascribed to them in the Privacy Rule and the Security Rule:

- a. Breach Notification Rule: the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.
- b. Business Associate: a person or entity who performs services for the Plan involving the use or disclosure of individually identifiable health information, as defined in 45 CFR Section 160.103.
- c. HIPAA: the Health Insurance Portability and Accountability Act of 1996, as amended.
- d. Plan Sponsor: The Curators of the University of Missouri
- e. Privacy Rule and Security Rule: HIPAA's implementing regulations at 45 CFR Parts 160, 162, and 164.
- f. Protected Health Information (“PHI”): individually identifiable health information as defined in 45 CFR Section 164.103.
- g. Summary Health Information: information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides Benefits under the Plan, as such information is defined in the Privacy Rule.
- h. Workforce Members: For purpose of this attachment, “workforce members” means UM System HR’s employees, volunteers, trainees, students, and other persons whose conduct, in the performance of work for the Plan Sponsor, is under the direct control of Plan Sponsor, whether or not they are paid for that work by the UM System HR.

Plan Sponsor’s Certification of Compliance

Neither the Plan nor any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants’ PHI to the Plan Sponsor unless the Plan Sponsor certifies that the Plan Documents have been amended to incorporate this Section and agrees to abide by this Section.

Purpose of Disclosure to Plan Sponsor

- a. The Plan and any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants’ PHI to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions for the Plan not

inconsistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing Regulations (45 CFR Parts 160-164). Any disclosure to and use by the Plan Sponsor of Plan Participants' PHI will be subject to and consistent with the provisions of this Section.

- b. Neither the Plan nor any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Participants by the Plan.
- c. Neither the Plan nor any health insurance issuer or Business Associate servicing the Plan will disclose Plan Participants' PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- d. The Plan may disclose Summary Health Information to Plan Sponsor.
- e. The Plan may disclose to Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled or has disenrolled from a particular coverage option within the Plan.

Restrictions on Plan Sponsor's Use and Disclosure of PHI

- a. The Plan Sponsor will neither use nor further disclose Plan Participants' PHI, except as permitted or required by the Plan Documents, as amended, or required by law.
- b. The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides Plan Participants' PHI agrees to the restrictions and conditions of the Plan Documents, including this Section, with respect to the Plan Participants' PHI.
- c. The Plan Sponsor will not use or disclose PHI that is Genetic Information about an individual for underwriting purposes. The term "underwriting purposes" includes determining eligibility for Benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.
- d. The Plan Sponsor will not use or disclose Plan Participants' PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- e. The Plan Sponsor will comply with the requirements of the HITECH Act and its implementing regulations to provide notification to affected individuals, HHS, and the media (when required) if the Plan Sponsor or one of its Business Associates discovers a breach of unsecured PHI.

- f. The Plan Sponsor will report to the Plan any use or disclosure of Plan Participants' PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.
- g. The Plan Sponsor will consider requests by a Plan Participant to restrict uses and disclosures of the Participant's PHI to carry out treatment, payment, or health care operations, or restrict uses and disclosures to the Participant's family members, relatives, friends or other persons identified by the Participant who are involved in care or payment of care. Except as otherwise provided, the Plan Sponsor is not required to agree to the Plan Participant's request; however, if the Plan Sponsor does agree to the request, the request will be honored until the Plan Participant revokes it, or until the Plan Sponsor notifies the individual that the Plan Sponsor will no longer honor the request. The Plan Sponsor must comply with the restriction request if: (1) except as otherwise provided by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for the purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the Health Care Provider involved has been paid out-of-pocket in full.
- h. The Plan Sponsor will make PHI available to the Plan Participant who is the subject of the information in accordance with 45 CFR Section 164.524.
- i. The Plan Sponsor will make Plan Participants' PHI available for amendment, and will on notice amend Plan Participants' PHI, in accordance with 45 CFR Section 164.526.
- j. The Plan Sponsor will track disclosures it may make of Plan Participants' PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR Section 164.528 and the HITECH Act and its implementing regulations.
- k. The Plan Sponsor will make available its internal practices, books and records, relating to its use and disclosure of Plan Participants' PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-164.
- l. The Plan Sponsor will, if feasible, return or destroy all Plan Participant PHI, in whatever form or medium, including any electronic medium under the Plan Sponsor's custody or control, received from the Plan, including all copies of any data or compilations derived from and allowing identification of any Participant who is the subject of the PHI, and retain no copies of such information when the Plan Participants' PHI is no longer needed for the purpose for which the disclosure was made. If it is not feasible to return or destroy all Plan Participant PHI, the Plan Sponsor will limit the use or disclosure of any Plan Participant PHI it cannot feasibly return or destroy to

those purposes that make the return or destruction of the information infeasible.

Adequate Separation Between the Plan Sponsor and the Plan

- a. The following classes of employees or other Workforce Members under the control of the Plan Sponsor may be given access to Plan Participants' PHI received from the Plan or a health insurance issuer or Business Associate servicing the Plan:

- 1) any employee who serves as the Plan Administrator;
- 2) any employee who serves as a Plan fiduciary; and
- 3) any employee who performs functions related to the Plan, including but not limited to human relations, audit, legal, accounting and systems personnel.

This list includes every class of employees or other Workforce Members under the control of the Plan Sponsor who may receive Plan Participants' PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

- b. The classes of employees or other Workforce Members identified in paragraph 5(a) of this Section will have access to Plan Participants' PHI only to perform the plan administration functions that the Plan Sponsor provides for the Plan.
- c. The classes of employees or other Workforce Members identified in paragraph 5(a) of this Section will be subject to the Plan Sponsor's disciplinary policies and procedures up to and including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of Plan Participants' PHI in breach or violation of or noncompliance with the provisions of this Section to the Plan Documents. Plan Sponsor will promptly report any such breach, violation or noncompliance to the Plan, as required by paragraph 4(d) of this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Plan Participant, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

Disclosures by Others to the Plan Sponsor

The Plan Sponsor shall be entitled to receive PHI from:

- a. the Plan;

- b. any Business Associate of the Plan;
- c. any person or entity that contracts with such Business Associate;
- d. any person or entity that contracts with the Plan Sponsor to provide services to or on behalf of the Plan;
- e. any health insurer or health insurance issuer or HMO that provides health Benefits coverage or services to or on behalf of the Plan;
- f. any health care clearinghouse that provides services to or on behalf of the Plan or with respect to Plan Participants; and
- g. any other person or entity that maintains, or has the authority to direct the disclosure of, PHI related to any Plan Participant.

Permitted and Required Uses and Disclosures of PHI

- a. Permitted Uses and Disclosures. The Plan Sponsor is and shall be entitled to use and disclose any PHI obtained pursuant to this Section only for the purposes of plan administration functions.
- b. Required Uses and Disclosures of PHI:

The Plan Sponsor shall be required to use and/or disclose PHI:

- 1) to an individual, when requested under, and required by 45 CFR Section 164.524, in order to provide an individual with access to their own PHI;
- 2) to an individual, when requested under, and required by 45 CFR Section 164.528, in order to provide an individual with an accounting of disclosures of that individual's PHI; and
- 3) when required by the Secretary of the Department of Health and Human Services or those acting under the authority or at the direction of the Secretary to investigate or determine the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule.

Prohibited Uses and Disclosures of PHI

The Plan Sponsor shall not be entitled to use or disclose PHI for any purpose for which use and disclosure is not expressly allowed under this Plan Document, including but not limited to:

- a. using or disclosing PHI other than as permitted or required under this document or applicable law, or in a manner inconsistent with the Privacy Rule or Security Rule; and
- b. taking adverse employment action against any Plan Participant who is an employee of Plan Sponsor, except with respect to any fraud or unlawful act related to the Plan and committed or reasonably suspected to have been committed by such person.
- c. Using or disclosing PHI that is genetic information for underwriting purposes.

Minimum Necessary

When using or disclosing PHI or when requesting PHI from another party, the Plan Sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

Security Provisions

- a. Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
- b. Plan Sponsor will ensure that the adequate separation required by Section 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- c. Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- d. Plan Sponsor will report to the Plan any security incident of which it becomes aware.

Mitigation

- a. In the event of noncompliance with any of the provisions set forth in this Section, the HIPAA Privacy Officer or Security Officer, as appropriate, will address any complaint promptly and confidentially. The HIPAA Privacy Officer or Security Officer, as appropriate, first will investigate the complaint and document the investigative efforts and findings.
- b. If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Section, the HIPAA Privacy Officer and/or the Security Officer, as appropriate, shall take immediate

steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

Breach Notification

Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR § 164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR § 164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR § 164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

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 eighteen (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, you may contact the Claims Administrator through **www.realappeal.com**, or at the number shown on your ID card.

**SUMMARY PLAN DESCRIPTION FOR
EXPRESS SCRIPTS PRESCRIPTION DRUG BENEFIT PLAN
FOR
THE CURATORS OF THE UNIVERSITY OF MISSOURI
EFFECTIVE JANUARY 1, 2025**

The following Prescription Drug Benefits are not administered by UnitedHealthcare. UnitedHealthcare makes no warranties or representations concerning the accuracy of the pharmacy benefits described on the following pages. The administrator for the pharmacy benefits is Express Scripts. No retail or mail-order prescription drug benefits will be paid through UnitedHealthcare.

**Express Scripts
Prescription Drug Benefit Plan for
The Curators of the University of Missouri**

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Express Scripts Prescription Drug Benefit Plan for The Curators of the University of Missouri

The Prescription Drug Program offers you Prescription Drug Coverage for most drugs and medicines prescribed by a Physician and dispensed by a licensed pharmacist, including syringes needed for administration of a drug, through Express Scripts, Inc. (ESI). ESI provides managed Prescription Drug services through an extensive national network of retail pharmacies as well as a mail-order Program. Eligibility for coverage, Effective Dates of coverage, termination of coverage, and continuation of coverage for Prescription Drug Benefits are as determined for health care coverage under the University's group health insurance plans.

Section 1 - Definitions

Adverse Benefit Determination - denial, reduction, or a failure to provide or make payment (in whole or in part) for a benefit.

Brand-Name Drug - a medication that is available only from its original manufacturer or from another manufacturer that has a licensing agreement to make the drug with the brand-name manufacturer. These medications are marketed under a recognized brand name. A brand-name drug may have a generic equivalent once the manufacturer is required to allow other manufacturers the opportunity to make the medication.

Copayment/Coinsurance - a portion of the total cost of the claim that must be paid by the member.

Date of Service - the date on which a prescription is filled or dispensed.

Days Supply - the number of days payable by the plan for the dispensed drug.

Deductible - the amount you pay for covered retail prescriptions before the plan begins to pay.

Direct Claim - a reimbursement process whereby the member pays 100% of the Prescription Drug cost at the time of purchase and then submits a paper claim for reimbursement.

Dispense-as-Written Rule - a plan rule that requires a member to use a generic equivalent drug instead of a brand name drug. If the member purchases a brand name drug when a generic equivalent is available, the member will pay the brand drug copayment plus the difference in cost between the brand name and generic drug.

Encircle Rx- a program that provides enhanced controls to ensure GLP-1 access to clinically necessary patients.

Enhanced Fraud, Waste, and Abuse Program - In addition to the standard monitoring for pharmacy fraud and abuse, Express Scripts offers the University of Missouri an Enhanced Fraud, Waste, and Abuse program. This service helps the University of Missouri identify members and prescribers who may be committing fraud or abusing the prescription

drug benefit. The program is designed to help identify members who may be at risk for opioid abuse and offers strategies to keep our members safe.

Federal Legend Drug - a drug that requires a prescription. These drugs can be identified by the presence of “Federal Legend” on the label.

Formulary - a list of commonly prescribed medications that have been selected based on their clinical effectiveness and opportunities for savings. An independent Pharmacy and Therapeutics committee updates this list regularly based on continuous evaluation of medications. You can contact Express Scripts at 1-800-955-1201 to determine if the brand-name drug you are taking is on the formulary. You can also locate this information at www.express-scripts.com. If a drug you are taking is *not* on the formulary, you may want to discuss alternatives with your Physician or pharmacist. Using drugs on the formulary will keep your costs and the University’s costs lower.

The plan formulary is subject to change from time to time. For example:

- A drug may be moved to a higher or lower copayment tier
- Additional drugs may be excluded from the formulary
- A limitation may be added on coverage for a formulary-covered drug (e.g., prior authorization or step therapy requirements)
- A formulary-covered brand name drug may be replaced with a formulary-covered generic drug

Formulary Brand Name Drug - a Brand Name Drug that is not a Non-Preferred Brand Name Drug.

Generic Drug - medication that is therapeutically equivalent to a brand medication, but manufactured at a lower cost. The Food and Drug Administration (FDA) requires generic medications to meet the same standards as Multi Source (Brand) Drugs.

Maintenance Medication (Long-term Therapy) - medications usually taken on a regular basis for Chronic Medical Conditions such as high blood pressure, arthritis, heart problems and diabetes. Maintenance/long-term therapy drugs may be purchased either at your local pharmacy or through mail-order service. You do receive a better level of Prescription Drug coverage for maintenance/long-term therapy drugs if you purchase through the mail-order service. Maintenance drugs are subject to the step therapy rule.

Mandatory Generic substitution - mandatory generic substitution applies to all Prescription Drugs. If there is a generic version of a brand drug which is prescribed, only the cost of the generic drug will be considered under the Prescription Drug unless prior authorization is obtained from Express Scripts for the member to receive the brand drug.

Member - a faculty or staff employee, or an eligible Dependent of a faculty or staff employee who is enrolled in a group health insurance plan sponsored by the University.

Multi Source (Brand) Drug - medication that has an FDA generic equivalent substitute available.

Network Pharmacy - a retail pharmacy that has an agreement currently in effect with Express Scripts for this Plan to dispense Prescription Drugs to members.

Network Retail Claims - claims processed by pharmacies that are included in the member's pharmacy network.

Non-Formulary Brand Name Drug - drugs which are not recommended based on their relative (to other available products) poor performance in efficacy, safety or cost. A non-formulary drug will be dispensed but a higher copay will be paid.

Out-of-Pocket Limit - the out-of-pocket limit places a cap on the amount the member will pay for eligible Prescription Drug expenses in one Calendar Year. The amount of your out-of-pocket limit is shown in the Schedule of Benefits.

Over-the-Counter (OTC) Products - medications or products that are available without a prescription or Physician intervention. Most of these products are not covered by the prescription benefit. Such medications are also known as non-legend drugs.

Plan -Prescription Drug benefit plan for the University.

Plan Year- the twelve (12) -month period beginning each January 1.

Prescription Drugs - any medical substance for which the label is required by the Federal Food, Drug and Cosmetic Act to bear the legend, "Caution: Federal Law prohibits dispensing without a prescription."

Prior Authorization - a Plan rule that requires a member or the member's Physician to obtain prior authorization for the use of certain medications. Without prior authorization, the member may not receive coverage for the medication.

SaveOnSP - administrator of specialty pharmacy co-pay/coinsurance assistance program.

Short-Term Therapy - medications commonly prescribed for Sicknesses like flu and strep throat, but may include the initial prescription for a new, long-term medication. You purchase these medications at a local pharmacy.

Specialty Drugs – high-cost drugs, including oral, topical, infused, and injectable drugs that are used to treat rare or complex diseases. Such drugs usually require special handling, require close clinical monitoring and management, and may have limited access or distribution.

Step Therapy Rule – a plan rule that requires the use of first-step therapies (generally Generics) before allowing the use of more expensive therapies. If your Physician determines that you need a brand-name drug for medical reasons, your Physician will need to request a Prior Authorization to obtain approval for the second-step drug. This does not apply to any drug used by a member currently using a step two medication as long as there is not more than a 130-day lapse between the refill of the drug.

The UM System Office of Human Resources – as used in this plan, this definition refers to the HR Service Center and your HR Generalist.

Section 2 - Schedule of Benefits

PRESCRIPTION DRUG		
Retail Prescription Drugs Supply limited to thirty-one (31) days <i>Deductible combined with medical deductible</i>	Non-Maintenance & Maintenance Medications	
	Network Pharmacy	
	Formulary Generic:	15% coinsurance after deductible
	Formulary Brand:	15% coinsurance after deductible
	Non-Formulary Brand:	15% coinsurance after deductible
	Non-Network Pharmacy: 35% coinsurance after deductible	
Mail Order Prescription <i>Deductible combined with medical deductible</i>	Maintenance Medications	
	Formulary Generic:	15% coinsurance after deductible
	Formulary Brand:	15% coinsurance after deductible
	Non-Formulary Brand:	15% coinsurance after deductible
Specialty Drugs* Supply limited to thirty-one (31) days <i>Deductible combined with medical deductible</i>	Specialty Medications	
	Must be obtained from a Mizzou Specialty Pharmacy or Accredo	
	Formulary Generic:	15% coinsurance after deductible
	Formulary Brand:	15% coinsurance after deductible
	Non-Formulary Brand:	15% coinsurance after deductible
Out of Pocket Limit	Prescription and medical out-of-pocket combined	
	Individual: \$3,750 in-network, \$7,000 out-of-network	
	Family: \$7,500 in-network, \$14,000 out-of-network	
<i>*Please see Section 3- Benefit Highlights, Specialty Drugs for information regarding the SaveOnSP program, which may impact your specialty drug cost share.</i>		

Section 3 - Benefit Highlights

Covered Expenses

- Generic or Formulary Brand Name Drugs requiring a prescription under Federal law (or applicable state law) including limited compound medications approved by the plan of which at least one ingredient is a federal legend drug;
- Diabetic supplies such as test strips, lancets, syringes and needles;
- Preventive prescription and over-the-counter medications and products as required by the Patient Protection and Affordable Care Act (PPACA). See the Preventive Medications and Products section below.

Direct Claims

Your plan provides for reimbursement of prescriptions when you pay 100% of the prescription price at the time of purchase. To request reimbursement, send your claim to Express Scripts, P. O. Box 14711, Lexington, KY 40512. This claim will be processed based on your plan benefit. If your claim is denied, you will receive a written notice within thirty (30) days of receipt of the claim, as long as all needed information was provided with the claim. You will be notified within this thirty (30)-day period if additional information is needed to process the claim, and a one-time extension not longer than fifteen (15) days may be requested and your claim pended until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame and the claim is denied, you will be notified of the denial within fifteen (15) days after the information is received. If you don't provide the needed information within the forty-five (45)-day period, your claim will be deemed denied.

Your plan allows coordination of benefits (COB). You are responsible for submitting a paper claim from other coverage to Express Scripts for reimbursement. To request reimbursement, send your claim to Express Scripts, P. O. Box 14711, Lexington, KY 40512. Express Scripts will reimburse according to your plan benefit; for example, applicable copay/coinsurance, formulary tier and coverage under the plan will apply. Processing for COB paper claims can take up to ten (10) business days.

EncircleRx Program for GLP-1's

EncircleRx is a weight loss program that provides enhanced controls to ensure GLP-1 access to clinically necessary members, improving clinical outcomes and lowering downstream medical and prescription costs. Higher patient body mass index (BMI) requirements of BMI ≥ 32 OR BMI 27- <32 with 2 documented cardiometabolic comorbidities, ensures that GLP-1s are prescribed to members who need them most to achieve a healthier weight. Enrollment and ongoing engagement in a lifestyle modification program, coupled with GLP-1s, provides the best outcomes in the weight loss journey.

The primary onboarding component of EncircleRx is mandatory self-enrollment in the Omada program, primarily self-directed. You will be contacted either via email or direct mail, where you will be provided an Access Code unique and specific to them. Through the email, you are able to click a link connected with this access code, or you can follow the URL provided on the direct mail and enter the access code on the entry page. You are required to stay engaged with the Omada app as set forth within the rules.

After onboarding, as the patient progresses along their journey, their prior authorization is reassessed to make sure they have lost the prerequisite body mass of 5%.

Express Scripts (Mail Order) Pharmacy for Long-term Therapy drugs

The Express Scripts Pharmacy mail order program is designed for plan members taking maintenance medications, or those medications taken on a regular basis, for the treatment of long-term conditions such as diabetes, arthritis or heart conditions. The program provides up to a 90-day supply of your maintenance medication, delivered directly to your home or other requested location, postage paid. No Deductible is required under the mail-order service program.

To fill your prescription through the Express Scripts Pharmacy, mail your 90-day prescription from your Physician, your completed Express Scripts Pharmacy prescription order form, and payment to: Express Scripts Home Delivery Service, P.O. Box 66577, St. Louis, MO 63166-6577. To order online, sign in at www.express-scripts.com and follow the prompts. To order over the phone, call Patient Customer Service at 1-800-955-1201 to speak with a Member Services representative. If you'd like, Express Scripts can contact your Physician to order your 90-day prescription.

To order refills, call Patient Customer Service at 1-800-955-1201 or visit the Order Center on www.express-scripts.com. Refills are normally processed and shipped within 3 to 5 days.

If you are a first-time visitor to the site please take a moment to register. Have your member ID and a prescription number available.

To ensure timely delivery, please place your orders at least two weeks in advance to allow for mail delays and other circumstances beyond our control. If you have any questions concerning your order, or if you do not receive your medication within the designated timeframe, please contact Patient Customer Service at 1-800-955-1201.

Network Retail Pharmacies

The Express Scripts pharmacy network is a national network comprised of more than 50,000 participating retail pharmacies. The network includes most major chains, discount, grocery and independent pharmacies, so there is a good chance that your local pharmacy is a participating member of the network. Use one of these Network Pharmacies to fill prescriptions for short-term medications, such as antibiotics. To find a local Network Pharmacy, visit www.express-scripts.com or contact Customer Service at 1-800-955-1201.

Nursing Home Coverage of Prescriptions

If a member resides in a nursing home, prescription coverage can be obtained through the nursing home pharmacy. Provide the nursing home with the Express Scripts information (located on your medical ID card) so that the pharmacy may file claims directly with Express Scripts. Network and Non-Network Coverages apply. If the nursing home pharmacy will not file the claim, forms are available at <http://umurl.us/TR> or you can contact your Benefit Representative or HR Service Center at <http://umurl.us/CBR>. You will need to complete

the claim forms, attach copies of the receipts and submit them directly to Express Scripts using the address located on the form.

Patient Customer Service

Visit Express Scripts' website, www.express-scripts.com, to view your plan design and copayment information, search for details on prescription medications, locate a Network Pharmacy near you, and manage your home delivery prescriptions. For additional plan inquiries, you may call Patient Customer Service directly at 1-800-955-1201. For future reference, this number is listed on the back of your Express Scripts ID card.

Prescription Drug ID Cards

Upon enrollment in a University medical plan, you will receive a member ID card from United HealthCare. This ID card will also contain your Prescription Drug information and must be presented when filling a prescription at a Network Pharmacy. Should you need additional information regarding prescriptions, please contact Express Scripts at 1-800-955-1201. If you need a replacement ID card, you can call 1-844-634-1237 or visit www.myuhc.com to request a new card or print a temporary card.

Preventive Medications and Products

In accordance with the requirements of the PPACA, the following preventive and contraceptive prescription and over-the-counter (OTC) medications and products prescribed by your Physician are covered for Members at no cost sharing, subject to the limitations outlined below:

Aspirin	Limited to age 45 through 70. Dose covered- 81mg
Bowel Preps	Limited to age 50 through 75
Fluoride	Limited to age 5 and under
Folic Acid	Limited to age 18 through 45
Immunizations	As recommended by CDC Advisory Committee
Smoking Cessation Products	Limited to age 18 and older
Vitamin D	Limited to age 65 and older
Prescription and OTC Contraceptive drugs and products (Barrier; generic and single-source/MS Daw1 brand hormonal; implanted devices; and Emergency contraceptives)	See Exclusions and Limitations
Breast Cancer Prevention -Tamoxifen and raloxifene (generics) and Soltamax (brand)	Requires copay review
Statins: Low/Moderate dose of generic statins	Limited to age 40 through 75

Aspirin	Limited to age 45 through 70. Dose covered- 81mg
HIV PrEP Standard Solution- Generic Emtricitabine/Tenofovir Disoproxil Fumarate (TDF).	\$0 copay limited to Members who meet the following criteria: <ul style="list-style-type: none"> • Dose Covered- 200mg/300mg • Absence of prescription claims for HIV treatment • No age limitation

Specialty Drugs

Due to the specialized nature and high cost of Specialty Drugs used to treat rare or complex medical conditions, such drugs may be subject to one or more coverage limits, such as Prior Authorization, Quantity/Duration Limits, or Step Therapy. All Specialty Drugs must be obtained through Mizzou Specialty Pharmacy or Express Scripts' specialty pharmacy Accredo Health Group, Inc. These drugs require a level of intervention and monitoring (beyond what is needed for a normal maintenance medication) to ensure quality outcomes.

- This plan has implemented a specialty pharmacy co-pay / coinsurance assistance program called SaveOnSP;
- Certain Specialty Pharmacy drugs are considered non-essential health benefits under the plan and the cost of such drugs will not be applied toward satisfying the participant's out-of-pocket maximum; although the cost of the Program drugs will not be applied towards satisfying a participant's out-of-pocket maximum, the cost of the Program drugs will be reimbursed by the manufacturer at no cost to the participant; and
- Copays / Coinsurances for certain specialty medications may be set to the maximum of the current plan design or any available manufacturer-funded copay assistance.

Short-term Therapy Drugs - Retail Pharmacy

For retail Prescription Drugs, you pay a separate calendar-year drug Deductible as shown above in the Schedule of Benefits for you and each family member. After the Prescription Drug Annual Deductible is met, your Benefits are paid based on whether or not your prescription is filled at a network pharmacy. The Prescription Drug Annual Deductible does not count toward any other Deductible or the medical out-of-pocket limit.

- If your prescription is filled at a participating ESI network pharmacy, then you pay a portion of the cost as shown in the Schedule of Benefits after you have met your Deductible. No claim form is required when you use your Prescription Drug identification card. Up to a 31-day supply will be provided when a prescription is filled.
- If you fill a brand name drug when a Generic is available, you will pay the applicable copayment plus the entire difference between the cost of the brand name drug and the Generic drug.

- ESI maintains a formulary, which is a list of commonly prescribed generic and brand-name drugs chosen for their quality and cost-effectiveness. The formulary is available at <http://umurl.us/TR> and also at the www.express-scripts.com.
- If your prescription is filled somewhere other than a network pharmacy, then you must pay the difference between the pharmacy's charge and the price an ESI pharmacy would charge for the same drug based on the discount prices negotiated by ESI, in addition to the Deductible and the applicable copay or Coinsurance. You must submit a claim form to receive reimbursement. Claim forms are available at <http://umurl.us/TR>.

Specialty Pharmacy Services

Express Scripts provides specialty pharmacy services for patients with certain complex and chronic conditions through Mizzou Specialty Pharmacy Services and Accredo Health Group, Inc.

The Mizzou Specialty Pharmacy service's website is www.muhealth.org/pharmacy/specialty-pharmacy-services and the phone number is (573) 882-8890. The Mizzou Specialty Pharmacy Services offers:

- Nationally accredited by URAC for compliance with the highest standards of patient safety and quality in specialty pharmacy
- Fully integrated with University of Missouri Health Care for seamless care coordination and access to clinicians 24 hours a day, 365 days a year
- Individualized support by Patient Medication Liaisons (PML) with expertise to help you save money on your specialty medications
- Monthly refill reminder calls to help you refill your medications on time
- Convenient, timely, confidential pick-up and delivery options

Accredo's website is www.accredo.com and Accredo's phone number is 1-800-955-1201. Accredo offers comprehensive therapy management solutions, including:

- Reimbursement services to review the patient's coverage and coordinate payment from the health plan and/or patient, as appropriate.
- Confidential and convenient delivery with packaging and handling protocols designed so medication arrives with integrity intact.
- Clinical services to assist the patient - under the supervision of their Physician - in implementing the prescribed course of treatment.
- Compliance programs to promote patient persistency and help the patient improve their quality of life.
- National Customer Support Center which provides patients with access to specialty-trained pharmacists and registered nurses 24 hours a day, 7 days a week

Accredo focuses on infused, injectable, and oral drugs that are very expensive and often have restrictions as determined by the FDA. These specialty drugs may be difficult to self-administer, have a potential for adverse reactions, and require temperature control or other specialized handling.

Vacation Supply/Overseas Pharmacies

A one-time 31-day vacation supply of prescriptions may be obtained from the local retail pharmacy.

For vacations in the US, arrangements may be made for early refills in either of two ways:

- A pharmacy can contact ESI's Help Desk to obtain an Authorization override for an early refill.
- The member may also contact ESI's Customer Services, explain when and how long they will be on vacation. The names and strengths of the drugs involved and the name and phone number of the pharmacy where they wish to purchase the medications needs to be provided to ESI.

The ESI network does not include pharmacies outside the continental United States. In addition, their mail order service cannot mail Prescription Drugs out of the U.S. Accordingly, receipts for any medications obtained out of the U.S. may be submitted directly to ESI for reimbursement, but bear in mind that the pharmacy program is operated in accordance with U.S. laws as they relate to prescribing Physicians as well as the Prescription Drugs themselves.

For a Leave of Absence or extended vacation out of the country: Employee must submit all of the following items to UM System Office of Human Resources within thirty (30) days prior to the scheduled departure:

- A copy of their Leave of Absence form or an explanation of the dates/duration of extended out-of-country vacation.
- A letter from the Physician stating, in effect, that the Physician agrees with or authorizes the dispensing of a (specified duration – not to exceed one year, if medication is a narcotic, a six-month limit applies).
- Employee must indicate whether or not they wish to fill the vacation supply through the ESI mail order pharmacy or provide the name and phone number of the retail pharmacy they wish to use.
- The employee is responsible for obtaining a prescription from the Physician sufficient to cover the supply of medications being requested at either ESI mail order or a local retail pharmacy. If the employee doesn't have enough refills already on file to cover the vacation supply they need to do the following depending on where they are filling their prescription:
 - Local Pharmacy: Employee must request physician provide a new script directly to the pharmacy.
 - ESI Mail Order: Employee must contact ESI Patient Customer Service at 1-800-955-1201 and provide them with the following information and authorize ESI to obtain a script on their behalf:

- Name of physician
- Physician's phone number
- Name of medication requested
- Day supply needed

If approved, UM System Office of Human Resources will inform ESI and instruct them to contact the employee to coordinate the fulfillment of the request.

University of Missouri Pharmacy for Long-term Therapy Drugs

Plan members taking maintenance medications, or those medications taken on a regular basis, for the treatment of long-term conditions such as diabetes, arthritis or heart conditions can obtain their drugs through University of Missouri Pharmacies. The cost structure is the same as the mail-order Benefits through Express Scripts, which is lower than the normal retail pharmacy network. The cost is shown in the Benefits Schedule in Section 2. The program provides up to a 90-day supply of your maintenance medication. No Deductible is required if you get greater than a 31 day supply at a University of Missouri Pharmacy.

Section 4 - Coverage Limits

Your plan may have certain coverage limits. For example, Prescription Drugs used for cosmetic purposes may not be covered, or a medication might be limited to a certain amount (such as the number of pills or total dosage) within a specific time period. If you submit a prescription for a drug that has coverage limits, your pharmacist will tell you that approval is needed before the prescription can be filled. The pharmacist will give you or your Physician a toll-free number to call. If you use the Express Scripts Pharmacy, your Physician will be contacted directly.

When a coverage limit is triggered, more information is needed to determine whether your use of the medication meets your plan's coverage conditions. Express Scripts will notify you and your Physician in writing of the decision. If coverage is approved, the letter will indicate the amount of time for which coverage is valid. If coverage is denied, an explanation will be provided, along with instructions on how to submit an Appeal.

Prior Authorization

Certain classes of drugs may require Prior Authorization to be covered. Please call Express Scripts at 1-800-955-1201 to determine if the medication you have been prescribed is subject to prior authorization.

Quantity/Dose Duration Limits

A quantity or dose duration limitation may be placed on certain therapeutic classes of drugs. Please call Express Scripts at 1-800-955-1201 to determine if the medication you have been prescribed is subject to quantity limits.

Step Therapy

Certain therapeutic classes of drugs may be subject to Step Therapy requirements. Please call Express Scripts at 1-800-955-1201 to determine if the medication you have been prescribed is subject to step therapy.

Section 5 - Exclusions

The following Prescription Drug charges are excluded from Covered Charges under this Plan:

- Administration - Any charge for the administration of a drug.
- Abuse/misuse – Under the Enhanced Fraud, Waste and Abuse Program, the University of Missouri has the option to “lock-in” a member to one pharmacy, physician or both to fill controlled substance, muscle relaxant and tramadol prescriptions. This allows the University of Missouri to efficiently manage and reduce risk to our membership from the dangers of opioid abuse. Members who are “locked-in” receive a series of letters from Express Scripts that notify the member of the change in their benefit and the effective date of that change.
- Athletic performance - Drugs and products used to enhance athletic performance, such as, but not limited to, anabolic steroids;
- Compounded prescriptions - A limited number of compounded ingredients are excluded from the Plan due to there being a suitable commercial alternative available.
- Contraceptives – Outside of Affordable Care Act (ACA), any contraceptive outpatient Prescription Drugs or devices not approved by the Food and Drug Administration and any over-the-counter contraceptive products, such as condoms and spermicidal agents.
- Cosmetic - Drugs and products used primarily for Cosmetic purposes, such as, but not limited to, drugs prescribed for the prevention of wrinkles, skin depigmentation or hair restoration or hair loss or drugs whose primary FDA indication is for Cosmetic use;
- Dental - Oral dental preparations and fluoride rinses except fluoride tablets or drops;
- Devices - Devices, implants or supplies of any type, even though such devices may require a Prescription Order, including, but not limited to, therapeutic devices, artificial appliances, non-disposable hypodermic needles, syringes, support garments or other devices, regardless of their intended use, except as specifically listed as a Covered Service in this SPD;
- Diabetic devices- Pre-filled insulin syringes or devices used to assist in insulin injection (except disposable syringes, glucose strips, lancets, glucose monitors, or any other Medically Necessary FDA-approved medication for use in the treatment of diabetes
- Dietary - Dietary and nutritional supplements, appetite suppressants, and other drugs used to treat obesity or assist in weight reduction and malabsorption agents; covered through Prior Authorization if you meet clinical criteria.
- Early refills - Prescriptions refilled before 75 percent of the previously dispensed supply should have been consumed when taken as prescribed.

- Enteral - Fluids, solutions, nutrients, or medication used or intended to be used by intravenous or gastrointestinal (enteral) infusion, or by intravenous injection in the home setting, except as specifically listed as a Covered Service in this SPD;
- Experimental or Investigational - Experimental or Investigational drugs or products, drugs prescribed for Experimental (non-FDA approved/unlabeled/ineffective) indications, including those labeled “Caution - Limited by Federal Law to Investigational Use”; FDA approved drugs used for Investigational indications or at Investigational doses and drugs found by the FDA to be ineffective or given as a part of a Clinical Trial or study.
- Growth hormones - Growth hormones, except that they are Covered when used to treat a congenital anomaly; provided you meet clinical criteria through Prior Authorization
- Illegality - Any Prescription Drug that is being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper; and drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Participant identification card, including drugs obtained for use by anyone other than the Participant identified on the identification card;
- Infertility - Drugs used for the treatment of Infertility or ovulation stimulation. ;
- Injectables - Injectable medications other than Self-Administered Injectables or Specialty Drugs as defined as designated by the health Plan, Glucagon, insulin, Imitrex and bee sting kits; (refer to the EOC for information regarding Coverage of Injectables under the medical Benefit);
- Inpatient– Drugs while you or your dependent are confined in a Hospital, Skilled Nursing Facility or similar facility;
- Loss/theft/damage - Refill of Prescription Drugs resulting from loss or theft or resulting damage by the Participant, beyond one-time exception.
- Medical Necessity - Any drugs which are not Medically Necessary and Appropriate or are in excess of the Reasonable and Customary Charges. (The Plan reserves the right to require Prior Authorization for selected drugs before providing Coverage).
- No Charge - Any medication for which the cost is recoverable under any federal, state, or governmental agency or any medication for which there is no charge made to the recipient; any reduction in claims or charges by the Health Care Provider after Benefits are paid by this Plan. All discounts or forgiven charges must be applied before Medical Expenses are submitted to the Claims Administrator.
- Non-Covered Drugs - Prescription Drugs not considered as Covered drugs or Prescription Drugs related to a non-Covered Service.
- Non-FDA approved drugs - Products not approved by the FDA, medications with no FDA approved indications, medications prescribed at dosages in excess of FDA approval;

- Non-Participating Pharmacies - Prescription Drugs obtained from non-Participating Pharmacies in non-emergent or non-urgent situations;
- Over-the-counter - Drugs and products that do not, by federal or state law, require a prescription to be dispensed, outside of ACA requirements, such as aspirin, antacids, herbal products, oxygen, medicated soaps, and bandages, or Prescription Drugs with non-Prescription Drug alternatives or over-the counter equivalents (e.g., Benadryl 25 mg) even if prescribed in the Generic form, unless as specifically noted in the drug Formulary; non-legend drugs other than injectable insulin;
- Prescription Drug Coverage does not extend to drugs or products that are not FDA-approved prescription medications, such as those without an approved FDA application (NDA, ANDA or BLA).
- Prior Authorization - Medications for which Prior Authorization is required from the Claim Service Contractor but for which it is not obtained.
- Sexual disorders - Drugs used in the treatment of sexual dysfunction including hypoactive sexual desire disorder and erectile dysfunction, including but not limited to Cialis and Viagra.
- Special packaging - The cost of special packaging required for drugs dispensed in nursing homes;
- Travel-related - Drugs prescribed and taken for the purpose of facilitating travel, outside of ACA requirements, including, but not limited to, medications, devices and supplies for motion Sickness or travel-related disease (e.g., relief bands, vaccines);
- Vitamins - Vitamins, supplements, replacements and minerals (both OTC and legend), outside of ACA requirements, except legend prenatal vitamins for pregnant/nursing persons and liquid or chewable legend pediatric vitamins for Children;
- Workers' compensation - Any medications for which the cost is recoverable under any workers' compensation or occupational disease law. Prescription entitled under Worker's Compensation and/or other municipal, state or federal Programs

Section 6 - Questions and Appeals

If you have a question or concern about a benefit determination, you may contact Express Scripts directly at 1-800-955-1201. If you are not satisfied with an Adverse Benefit Determination, you may Appeal it as described below.

For non-urgent claims, including direct claims:

In the event you receive an Adverse Benefit Determination following a request for coverage of a prescription benefit claim, you have the right to Appeal the Adverse Benefit Determination in writing within one hundred eighty (180) days of receipt of notice of the initial coverage decision. A written Appeal may be initiated by you or your Authorized Representative (such as your Physician), and should be sent to Express Scripts, Inc., Express Scripts, P.O. Box 66588, St. Louis, MO. 63166-6588, Attn: Clinical Appeals Department. The following information should be included in your written request:

1. Your name and Express Scripts member ID number.
2. Your telephone number.
3. The provider's name.
4. The date of request for Prescription Drug.
5. The Prescription Drug for which benefit coverage has been denied.
6. The diagnosis code and treatment codes to which the prescription relates.
7. Any documentation or additional information relevant to the Appeal.

A decision regarding your Appeal will be sent to you within fifteen (15) days of receipt of your written request. The notice will include the specific reasons for the decision, the plan provisions on which the decision is based, a description of applicable internal review processes, and contact information for an office of consumer assistance that might be available to assist you with the claims and Appeals process and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your Appeal.

Second Level Appeal

If you are not satisfied with the coverage decision made on Appeal, you may request in writing, within 90 days of the receipt of notice of the decision, a second level Appeal. The second level Appeal may be initiated by you or your Authorized Representative (such as your Physician), and should be mailed to Express Scripts, P.O. Box 66588, St. Louis, MO 63166-6588, Attn: Clinical Appeals Department. The following information should be included in your formal written request:

1. Your name and Express Scripts member ID number.
2. Your telephone number.
3. The provider's name.
4. The date of request for Prescription Drug.
5. The Prescription Drug for which benefit coverage has been denied.
6. The diagnosis code and treatment codes to which the prescription relates.
7. Any documentation or additional information relevant to the Appeal.

You have the right to review your file and present evidence and testimony as part of your Appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within fifteen (15) days of receipt of your written request for Appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, any new or additional evidence considered by the plan in relation to your Appeal, and the plan provisions on which the decision is based. You have the right to receive, upon request and at no charge, the information used to review your second level Appeal.

External Review

If your second level Appeal is denied, you also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an Adverse Benefit Determination. External reviews are not available for decisions relating to eligibility.

For Urgent Claims:

In the case of a claim for coverage involving Urgent Care, you will be notified of the benefit determination within 72 hours of receipt of the claim. An Urgent Care claim is any claim for treatment where the application of the time periods for making non-Urgent Care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, Benefits are covered, you will be notified within seventy-two (72) hours after receipt of your claim of the information necessary to complete the claim. You will then have forty-eight (48) hours to provide the information and will be notified of the decision within twenty-four (24) hours of receipt of the information. If you don't provide the needed information within the forty-eight (48)-hour period, your claim will be deemed denied.

You have the right to request an urgent Appeal of an Adverse Benefit Determination for Urgent Care claims. Urgent Appeal requests may be sent by mail or fax. You or your Physician may write to Express Scripts, P.O. Box 66588, St. Louis, MO 63166-6588, Attn: Clinical Appeals Department. or send a fax to 1-877-852-4070. For general urgent issues, you may also call Patient Customer Service at 800-955-1201. In the case of an urgent Appeal for coverage involving Urgent Care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your Appeal.

External Review

You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function, you have the right to immediately request an expedited external review, prior to exhausting the internal Appeal process, provided you simultaneously file your request for an internal Appeal of the Adverse Benefit Determination. Details about the process to initiate an external review will be described in any notice of an Adverse Benefit Determination.

Limitation of Action:

You cannot bring any legal action against the University or Express Scripts to recover reimbursement until ninety (90) days after you have properly submitted a request for reimbursement as described in this section and all reviews of your claim, including an initial claim, first-level Appeal, second-level Appeal and external review, have been completed. If you want to bring a legal action against the University or Express Scripts, you must do so within three (3) years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the University or Express Scripts.

You cannot bring any legal action against the University or Express Scripts for any other reason unless you first complete all the steps in the Appeal process described in this section, including the first-level Appeal, second-level Appeal and external review. After completing that process, if you want to bring a legal action you must do so within three (3) years of the date you are notified of the final decision on your Appeal or you lose any rights to bring such an action against the University or Express Scripts.