JEFFERSON CITY PUBLIC SCHOOL DISTRICT
JEFFERSON CITY MO

Health Benefit Summary Plan Description (HDHP)
7670-00-410722

Revised 07-01-2018

BENEFITS ADMINISTERED BY

A UnitedHealthcare Company

Table of Contents

JEFFERSON CITY PUBLIC SCHOOL DISTRICT

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as information on a Covered Person's rights and obligations under the JEFFERSON CITY PUBLIC SCHOOL DISTRICT Health Benefit Plan (the "Plan"). As a valued Employee of JEFFERSON CITY PUBLIC SCHOOL DISTRICT, we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

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

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket, and Plan Participation amounts as described in the Schedule of Benefits.

The Plan Administrator believes Benefit Plan(s) 001, 002 are “grandfathered health plans” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Questions regarding which protection apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at:

315 E DUNKLIN ST
JEFFERSON CITY MO 65101
573-659-3014

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.cciio.cms.gov.

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

Individuals covered under this Plan will be receiving an identification card to present to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

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

This document becomes effective on July 1, 2010.

PLAN INFORMATION

Plan Name	JEFFERSON CITY PUBLIC SCHOOL DISTRICT GROUP BENEFIT PLAN
Name And Address Of Employer	JEFFERSON CITY PUBLIC SCHOOL DISTRICT 315 E DUNKLIN ST JEFFERSON CITY MO 65101
Name, Address And Phone Number Of Plan Administrator	JEFFERSON CITY PUBLIC SCHOOL DISTRICT 315 E DUNKLIN ST JEFFERSON CITY MO 65101 573-659-3014
Named Fiduciary	JEFFERSON CITY PUBLIC SCHOOL DISTRICT
Employer Identification Number Assigned By The IRS	44-6003078
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name, Title, And Address Of The Principal Place Of Business Of Each Trustee Of The Plan (If The Plan Has A Trust)	JEFFERSON CITY PUBLIC SCHOOL MEDICAL TRUST 315 E DUNKLIN ST JEFFERSON CITY MO 65101
Name And Address Of Agent For Service Of Legal Process	JEFFERSON CITY PUBLIC SCHOOLS 315 E DUNKLIN ST JEFFERSON CITY MO 65101 Services of legal process may also be made upon the Plan Administrator or plan trustee.
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on July 1 and end on the following June 30. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through June 30 of the same Benefit Plan Year.
Plan's Fiscal Year	July 1 through June 30

Compliance

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

Discretionary Authority

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

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001

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

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

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

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Plan Year:		
• Per Person	$1,000	$2,000
• Per Family	$2,000	$4,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum:		
• Per Person	$3,000	$6,000
• Per Family	$6,000	$12,000
Ambulance Transportation:		
• Paid By Plan After In-Network Deductible	80%	80%
Autism Services:		
To Age 19		
• Maximum Benefit Per Calendar Year	$44,760	
• Paid By Plan After Deductible	80%	60%
Breast Pumps:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Chiropractic Services:		
• Maximum Visits Per Plan Year	26 Visits	
Office Visit:		
Included In Maximum		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Manipulations:		
Included In Maximum		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
X-rays, Therapies And Modalities:		No Benefit
• Paid By Plan After Deductible	80%	

	IN-NETWORK	OUT-OF-NETWORK
Contraceptive Methods And Contraceptive Counseling Approved By The FDA:		
For Men:		
• Paid By Plan After Deductible	100%	60%
For Women:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Counseling Services:		
• Paid By Plan After Deductible	80%	60%
Marriage:		
• Maximum Visits Per Plan Year	2 Visits	
• Paid By Plan After Deductible	80%	60%
Durable Medical Equipment:		
• Paid By Plan After Deductible	80%	60%
Emergency Services / Treatment:		
Urgent Care:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	80%	60%
Emergency Room / Emergency Physicians:		
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$100	$100
• Paid By Plan After In-Network Deductible	80%	80%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility:		
• Co-pay Per Admission	$100	$100
• Maximum Days Per Plan Year	70 Days	
• Paid By Plan After Deductible	80%	60%
Genetic Counseling Or Testing:		No Benefit
• Paid By Plan After Deductible	80%	
Home Health Care Benefits:		
• Maximum Visits Per Plan Year	100 Visits	
• Paid By Plan After Deductible	80%	60%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits:		
Hospice Services:		
• Maximum Visits Per Plan Year	100 Visits	
• Paid By Plan After Deductible	80%	60%
Bereavement Counseling:		
• Paid By Plan After Deductible	80%	60%

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	80%	60%
Inpatient Services Only:		
• Co-pay Per Admission	$100	$100
• Paid By Plan After Deductible	80%	60%
Inpatient Physician Charges Only:		
• Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Imaging Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	80%	60%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	80%	60%
Jobst Stockings:		
• Maximum Benefit Per Plan Year	2 Pair	
• Paid By Plan After Deductible	80%	60%
Maternity / Pregnancy Services:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Non-Routine Prenatal Services, Delivery, And Postnatal Care:		
• Paid By Plan After Deductible	80%	60%
Note: The Amount You Pay Is Based On Where The Covered Health Service Is Provided. Examples Include But Are Not Limited To The Following: For Covered Health Services Provided In The Physician's Office, A Copayment Will Apply Only To The Initial Office Visit, If Applicable. Benefits For Pregnancy During An Inpatient Stay In A Hospital Will Be The Same As Found Under Hospital-Inpatient Stay. Benefits For Laboratory Services Associated With Pregnancy Will Be The Same As Found Under Lab, X-ray And Diagnostics-Outpatient. Benefits For Pharmaceutical Products For Pregnancy Received On An Outpatient Basis Will Be The Same As Found Under Pharmaceutical Products-Outpatient.		

	IN-NETWORK	OUT-OF-NETWORK
Mental Health, Substance Use Disorder And Chemical Dependency Benefits:		
Inpatient Services Only:		
• Co-pay Per Admission	$100	$100
• Paid By Plan After Deductible	80%	60%
Inpatient Physician Charges Only:		
• Paid By Plan After Deductible	80%	60%
Residential Treatment Only:		
• Co-pay Per Admission	$100	$100
• Paid By Plan After Deductible	80%	60%
Residential Physician Charges Only:		
• Paid By Plan After Deductible	80%	60%
Outpatient Or Partial Hospitalization Services And Physician Charges:		
• Paid By Plan After Deductible	80%	60%
Office Visit:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Physician Office Visit:		
Office Visit:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Specialist Visit:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Subsequent Visits:		
• Paid By Plan After Deductible	80%	60%
Physician Office Services:		
• Paid By Plan After Deductible	80%	60%
Allergy Injections:		
• Co-pay Per Visit	$5	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Allergy Serum:		
• Co-pay Per Visit	$5	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Allergy Testing:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		No Benefit
Preventive / Routine Physical Exams At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	
Immunizations:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Mammograms And Breast Exams, Including 3-D Mammograms:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Pelvic Exams And Pap Test:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine PSA Test And Prostate Exams:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Autism Screening: From Age 0 To Age 21		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Hearing Exams:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Eye Exam And Glaucoma Testing:		
• Maximum Exams Per Plan Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	

	IN-NETWORK	OUT-OF-NETWORK
Eye Refractions: • Maximum Exams Per Plan Year • Paid By Plan	 1 Exam 100% (Deductible Waived)	
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition: • Paid By Plan	 100% (Deductible Waived)	
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Treatment For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan ***These Services May Also Apply To Men.**	 100% (Deductible Waived)	
Sonogram: • Maximum Benefit Per Pregnancy • Paid By Plan After Deductible	 1 Sonogram 80%	 60%
Sterilizations: **For Men:** • Paid By Plan After Deductible **For Women:** • Paid By Plan After Deductible	 80% 100% (Deductible Waived)	 60% 60%
Temporomandibular Joint Disorder Benefits: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	 $1,000 80%	 60%
Therapy Services: **Occupational Outpatient Hospital And Office Therapy:** • Co-pay Per Visit • Maximum Visits Per Plan Year • Paid By Plan After Deductible **Physical Outpatient Hospital And Office Therapy:** • Co-pay Per Visit • Maximum Visits Per Plan Year • Paid By Plan After Deductible	 $35 60 Visits 100% (Deductible Waived) $35 60 Visits 100% (Deductible Waived)	 Not Applicable 60% Not Applicable 60%

	IN-NETWORK	OUT-OF-NETWORK
Speech Outpatient Hospital And Office Therapy:		
• Co-pay Per Visit	$35	Not Applicable
• Maximum Visits Per Plan Year	60 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	60%
Wigs, Toupees Or Hairpieces For Cancer Treatment Only:		
• Maximum Benefit Per Lifetime	$250	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
All Other Covered Expenses:		
• Paid By Plan After Deductible	80%	60%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 002

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

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

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

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Plan Year:		
• Per Person	$500	$1,000
• Per Family	$1,000	$2,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	90%	70%
Annual Out-Of-Pocket Maximum:		
• Per Person	$1,500	$3,000
• Per Family	$3,000	$6,000
Ambulance Transportation:		
• Paid By Plan After In-Network Deductible	90%	90%
Autism Services:		
To Age 19		
• Maximum Benefit Per Calendar Year	$44,760	
• Paid By Plan After Deductible	90%	70%
Breast Pumps:		
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Chiropractic Services:		
• Maximum Visits Per Plan Year	26 Visits	
Office Visit:		
Included In Maximum		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Manipulations:		
Included In Maximum		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
X-rays, Therapies And Modalities:		No Benefit
• Paid By Plan After Deductible	90%	

	IN-NETWORK	OUT-OF-NETWORK
Contraceptive Methods And Contraceptive Counseling Approved By The FDA:		
For Men:		
• Paid By Plan After Deductible	100%	70%
For Women:		
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Counseling Services:		
• Paid By Plan After Deductible	90%	70%
Marriage:		
• Maximum Visits Per Plan Year	2 Visits	
• Paid By Plan After Deductible	90%	70%
Durable Medical Equipment:		
• Paid By Plan After Deductible	90%	70%
Emergency Services / Treatment:		
Urgent Care:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	90%	70%
Emergency Room / Emergency Physicians:		
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$100	$100
• Paid By Plan After In-Network Deductible	90%	90%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility:		
• Co-pay Per Admission	$100	$100
• Maximum Days Per Plan Year	70 Days	
• Paid By Plan After Deductible	90%	70%
Genetic Counseling Or Testing:		No Benefit
• Paid By Plan After Deductible	90%	
Home Health Care Benefits:		
• Maximum Visits Per Plan Year	100 Visits	
• Paid By Plan After Deductible	90%	70%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits:		
Hospice Services:		
• Maximum Visits Per Plan Year	100 Visits	
• Paid By Plan After Deductible	90%	70%
Bereavement Counseling:		
• Paid By Plan After Deductible	90%	70%

	IN-NETWORK	OUT-OF-NETWORK
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	90%	70%
Inpatient Services Only:		
• Co-pay Per Admission	$100	$100
• Paid By Plan After Deductible	90%	70%
Inpatient Physician Charges Only:		
• Paid By Plan After Deductible	90%	70%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	90%	70%
Outpatient Imaging Charges:		
• Paid By Plan After Deductible	90%	70%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	90%	70%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	90%	70%
Jobst Stockings:		
• Maximum Benefit Per Plan Year	2 Pair	
• Paid By Plan After Deductible	90%	70%
Maternity / Pregnancy Services:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Non-Routine Prenatal Services, Delivery, And Postnatal Care:		
• Paid By Plan After Deductible	90%	70%
Note: The Amount You Pay Is Based On Where The Covered Health Service Is Provided. Examples Include But Are Not Limited To The Following: For Covered Health Services Provided In The Physician's Office, A Copayment Will Apply Only To The Initial Office Visit, If Applicable. Benefits For Pregnancy During An Inpatient Stay In A Hospital Will Be The Same As Found Under Hospital-Inpatient Stay. Benefits For Laboratory Services Associated With Pregnancy Will Be The Same As Found Under Lab, X-ray And Diagnostics-Outpatient. Benefits For Pharmaceutical Products For Pregnancy Received On An Outpatient Basis Will Be The Same As Found Under Pharmaceutical Products-Outpatient.		

	IN-NETWORK	OUT-OF-NETWORK
Mental Health, Substance Use Disorder And Chemical Dependency Benefits:		
Inpatient Services Only:		
• Co-pay Per Admission	$100	$100
• Paid By Plan After Deductible	90%	70%
Inpatient Physician Charges Only:		
• Paid By Plan After Deductible	90%	70%
Residential Treatment Only:		
• Co-pay Per Admission	$100	$100
• Paid By Plan After Deductible	90%	70%
Residential Physician Charges Only:		
• Paid By Plan After Deductible	90%	70%
Outpatient Or Partial Hospitalization Services And Physician Charges:		
• Paid By Plan After Deductible	90%	70%
Office Visit:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Physician Office Visit:		
Office Visit:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Specialist Visit:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Subsequent Visits:		
• Paid By Plan After Deductible	90%	70%
Physician Office Services:		
• Paid By Plan After Deductible	90%	70%
Allergy Injections:		
• Co-pay Per Visit	$5	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Allergy Serum:		
• Co-pay Per Visit	$5	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Allergy Testing:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	70%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		No Benefit
Preventive / Routine Physical Exams:		
• Paid By Plan	100% (Deductible Waived)	
Immunizations:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Mammograms And Breast Exams, Including 3-D Mammograms:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Pelvic Exams And Pap Test:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine PSA Test And Prostate Exams:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Autism Screening: From Age 0 To Age 21		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Hearing Exams:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Eye Exam And Glaucoma Testing:		
• Maximum Exams Per Plan Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	

	IN-NETWORK	OUT-OF-NETWORK
Eye Refractions:		
• Maximum Exams Per Plan Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition:		
• Paid By Plan	100% (Deductible Waived)	
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Treatment For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***		
• Paid By Plan	100% (Deductible Waived)	
***These Services May Also Apply To Men.**		
Sonogram:		
• Maximum Benefit Per Pregnancy	1 Sonogram	
• Paid By Plan After Deductible	90%	70%
Sterilizations:		
For Men:		
• Paid By Plan After Deductible	90%	70%
For Women:		
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Temporomandibular Joint Disorder Benefits:		
• Maximum Benefit Per Lifetime	$1,000	
• Paid By Plan After Deductible	90%	70%
Therapy Services:		
Occupational Outpatient Hospital And Office Therapy:		
• Co-pay Per Visit	$35	Not Applicable
• Maximum Visits Per Plan Year	60 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Physical Outpatient Hospital And Office Therapy:		
• Co-pay Per Visit	$35	Not Applicable
• Maximum Visits Per Plan Year	60 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	70%

	IN-NETWORK	OUT-OF-NETWORK
Speech Outpatient Hospital And Office Therapy:		
• Co-pay Per Visit	$35	Not Applicable
• Maximum Visits Per Plan Year	60 Visits	
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Wigs, Toupees Or Hairpieces For Cancer Treatment Only:		
• Maximum Benefit Per Lifetime	$250	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
All Other Covered Expenses:		
• Paid By Plan After Deductible	90%	70%

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 003, 004

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays (apply after Deductible is met, except for Preventive / Routine Care), Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

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

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

Notes: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Plan Year ***Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible*** • Single Coverage • Family Coverage	 $1,500 $3,000	 $3,000 $6,000
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	 100%	 70%
Annual Out-Of-Pocket Maximum ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum*** • Single Coverage • Family Coverage	 $3,000 $6,000	 $6,000 $12,000
Ambulance Transportation: • Paid By Plan After In-Network Deductible	 100%	 100%
Autism Services: To Age 19 • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	 $44,760 100%	 70%
Breast Pumps: • Paid By Plan After Deductible	 100% (Deductible Waived)	 70%

	IN-NETWORK	OUT-OF-NETWORK
Contraceptive Methods And Counseling Approved By The FDA:		
For Men:		
• Paid By Plan After Deductible	100%	70%
For Women:		
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Counseling Services:		
• Paid By Plan After Deductible	100%	70%
Marriage:		
• Maximum Visits Per Plan Year	2 Visits	
• Paid By Plan After Deductible	100%	70%
Durable Medical Equipment:		
• Paid By Plan After Deductible	100%	70%
Emergency Services / Treatment:		
Urgent Care:		
• Co-pay Per Visit	$35	$35
• Paid By Plan After Deductible	100%	70%
Emergency Room / Emergency Physicians:		
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$100	$100
• Paid By Plan After In-Network Deductible	100%	100%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility:		
• Co-pay Per Admission	$100	$100
• Maximum Days Per Plan Year	70 Days	
• Paid By Plan After Deductible	100%	70%
Genetic Counseling Or Testing:		No Benefit
• Paid By Plan After Deductible	100%	
Home Health Care Benefits:		
• Maximum Visits Per Plan Year	100 Visits	
• Paid By Plan After Deductible	100%	70%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits:		
Hospice Services:		
• Maximum Visits Per Plan Year	100 Visits	
• Paid By Plan After Deductible	100%	70%
Bereavement Counseling:		
• Paid By Plan After Deductible	100%	70%
Hospital Services:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	100%	70%

	IN-NETWORK	OUT-OF-NETWORK
Inpatient Services Only:		
• Co-pay Per Admission	$100	$100
• Paid By Plan After Deductible	100%	70%
Inpatient Physician Charges Only:		
• Paid By Plan After Deductible	100%	70%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	100%	70%
Outpatient Imaging Charges:		
• Paid By Plan After Deductible	100%	70%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	100%	70%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	100%	70%
Jobst Stockings:		
• Maximum Benefit Per Plan Year	2 Pair	
• Paid By Plan After Deductible	100%	70%
Manipulations:		
• Co-pay Per Visit	$35	Not Applicable
• Maximum Visits Per Calendar Year	26 Visits	
• Paid By Plan After Deductible	100%	70%
Maternity / Pregnancy Services:		
Routine Prenatal Services:		
• Paid By Plan After Deductible	100% (Deductible Waived)	70%
Non-Routine Prenatal Services, Delivery And Postnatal Care:		
• Paid By Plan After Deductible	100%	70%
N Note: The Amount You Pay Is Based On Where The Covered Health Service Is Provided. Examples Include But Are Not Limited To The Following: For Covered Health Services Provided In The Physician's Office, A Copayment Will Apply Only To The Initial Office Visit, If Applicable. Benefits For Pregnancy During An Inpatient Stay In A Hospital Will Be The Same As Found Under Hospital-Inpatient Stay. Benefits For Laboratory Services Associated With Pregnancy Will Be The Same As Found Under Lab, X-ray And Diagnostics-Outpatient. Benefits For Pharmaceutical Products For Pregnancy Received On An Outpatient Basis Will Be The Same As Found Under Pharmaceutical Products-Outpatient.		

	IN-NETWORK	OUT-OF-NETWORK
Mental Health, Substance Use Disorder And Chemical Dependency Benefits:		
Inpatient Services Only:		
• Co-pay Per Admission	$100	$100
• Paid By Plan After Deductible	100%	70%
Inpatient Physician Charges Only:		
• Paid By Plan After Deductible	100%	70%
Residential Treatment Only:		
• Co-pay Per Admission	$100	$100
• Paid By Plan After Deductible	100%	70%
Residential Physician Charges Only:		
• Paid By Plan After Deductible	100%	70%
Outpatient Or Partial Hospitalization Services And Physician Charges:		
• Paid By Plan After Deductible	100%	70%
Office Visit:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan After Deductible	100%	70%
Physician Office Visit:		
Office Visit:		
• Co-pay Per Visit	$25	Not Applicable
• Paid By Plan After Deductible	100%	70%
Specialist Visit:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100%	70%
Physician Office Services:		
• Paid By Plan After Deductible	100%	70%
Allergy Injections:		
• Co-pay Per Visit	$5	Not Applicable
• Paid By Plan After Deductible	100%	70%
Allergy Serum:		
• Co-pay Per Visit	$5	Not Applicable
• Paid By Plan After Deductible	100%	70%
Allergy Testing:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100%	70%
Subsequent Visits:		
• Paid By Plan After Deductible	100%	70%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		No Benefit
Preventive / Routine Physical Exams At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	
Immunizations:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Diagnostic Tests, Lab And X-rays At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Mammograms And Breast Exams, Including 3-D Mammograms:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Pelvic Exams And Pap Test:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine PSA Test And Prostate Exams:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Autism Screening: From Age 0 To Age 21		
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
• Maximum Visits Per Plan Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Hearing Exams:		
• Paid By Plan After Deductible	100% (Deductible Waived)	

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Eye Exam And Glaucoma Testing: • Maximum Visits Per Plan Year • Paid By Plan After Deductible **Eye Refractions:** • Maximum Visits Per Plan Year • Paid By Plan After Deductible **Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet And Nutrition:** • Paid By Plan **In Addition, The Following Preventive / Routine For Women Services Are Covered:** ➢ **Gestational Diabetes** ➢ **Papillomavirus DNA Testing** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling for Human Immune-deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies and Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan ***These Services May Also Apply To Men.**	 1 Exam 100% (Deductible Waived) 1 Exam 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived)	
Sonogram: • Maximum Benefit Per Pregnancy • Paid By Plan After Deductible	 1 Sonogram 100%	 70%
Sterilizations: **For Men:** • Paid By Plan After Deductible **For Women:** • Paid By Plan After Deductible	 100% 100% (Deductible Waived)	 70% 70%
Temporomandibular Joint Disorder Benefits: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	 $1,000 100%	 70%
Therapy Services: **Occupational Outpatient Hospital And Office Therapy:** • Co-pay Per Visit • Maximum Visits Per Plan Year • Paid By Plan After Deductible	 $35 60 Visits 100%	 Not Applicable 70%

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital And Office Therapy:		
• Co-pay Per Visit	$35	Not Applicable
• Maximum Visits Per Plan Year	60 Visits	
• Paid By Plan After Deductible	100%	70%
Speech Outpatient Hospital And Office Therapy:		
• Co-pay Per Visit	$35	Not Applicable
• Maximum Visits Per Plan Year	60 Visits	
• Paid By Plan After Deductible	100%	70%
Wigs, Toupees Or Hairpieces For Cancer Treatment Only:		
• Maximum Benefit Per Lifetime	$250	
• Paid By Plan After Deductible	100%	100%
All Other Covered Expenses:		
• Paid By Plan After Deductible	100%	70%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 001	
Transplant Services At A Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible	 80%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 002	
Transplant Services At A Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible	 90%

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 003, 004	
Transplant Services At A Designated Transplant Facility: **Transplant Services:** • Paid By Plan After Deductible	 100%

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 001 and 002

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles or out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

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

Deductible amounts are shown on the Schedule of Benefits.

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

The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total individual and family Deductible.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

If two or more covered family members are injured in the same Accident, only one Deductible needs to be met for those Covered Expenses which are due to that Accident, and Incurred during that Plan Year.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

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

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs do not apply toward the out-of-pocket maximum of this Plan.

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

- Co-pays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.

- Any charges above the limits specified elsewhere in this document.
- Co-pays and Participation amounts for Prescription products.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 003 and 004

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

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

Deductible amounts are shown on the Schedule of Benefits. Generally, the applicable Deductible must be met before any benefits will be paid under this Plan. However, certain covered benefits may be considered Preventative / Routine Care and paid first dollar.

The Deductible amounts that the Covered Person incurs for Covered Expenses, including covered Pharmacy expenses, will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total individual and family Deductible.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

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

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs apply toward the out-of-pocket maximum of this Plan.

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

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

The Covered Person's ability to contribute to a Health Savings Account (HSA) on a tax favored basis may be affected by any arrangement that waives this Plan's Deductible.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

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

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time 20 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased employees.
- An Independent Contractor as defined in this Plan.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential Special Enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for Special Enrollment. See the Special Enrollment section.

An **eligible Dependent** includes:

- Your legal spouse, as defined by the state in which You reside, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

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

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

- A Dependent does not include the following:

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

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

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

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

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

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

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

and the Dependent Child fits the following category:

- If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 31 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

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

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

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

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

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If You apply within 30 days of hire, Your coverage will become effective Your date of hire; or
- If You apply after 30 days of hire, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective July 1 following application during the annual open enrollment period. (Persons who apply under the Special Enrollment Provision are not considered Late Enrollees).
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 31 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

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

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 31 days of acquiring the Dependent; or
- July 1 following application during the annual open enrollment period. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 31 days following the date You acquire the Dependent; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 31 days following the event; or
- The later of the date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PROVISION

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Eligible Employees and their Dependents who enroll during the annual open enrollment period will be considered Late Enrollees. Covered Employees will be able to make a change in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

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

- The annual open enrollment period shall typically be in the month of May. The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and

- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and

- The Effective Date of coverage shall be July 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

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

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

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents may have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage.

If the following conditions are met:

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

- You and/or Your Dependent stated in writing that the reason for declining coverage was due to coverage under another group health plan or health insurance policy; and

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

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage is offered; or
  - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

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

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

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

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

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 31 calendar days of marriage, birth, adoption or Placement for Adoption.

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

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

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

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

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

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

EMPLOYEE'S COVERAGE

For staff that have contracts with JCPS, termination will coincide with the terms of Your contract.

For all other staff, Your coverage under this Plan will end on the earliest of:

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

YOUR DEPENDENT'S COVERAGE

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

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends except in the event that the Employee/Retiree turns 65 and drops off of the plan or dies, the Dependent will remain active under their own member ID provided that the Dependent pays the applicable contribution when due; or
- The day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section, unless the Child qualifies for Extended Dependent Coverage; or
- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

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

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

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

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

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

RESCISSION OF COVERAGE

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

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

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

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 26-week period, You will be treated as a new hire and will be required to meet all of the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

RETIRED EMPLOYEE COVERAGE

This Retired Employee Coverage provision applies only to former Employees who have coverage under the Plan on account of their status as Retired Employees. The purpose of this provision is to describe differences between the coverage provided to Employees and their Dependents, and the coverage provided to Retired Employees and their Dependents.

Where the terms of this provision expressly describe a benefit, right, responsibility or limitation applicable to a Retired Employee, which contradicts a benefit, right, responsibility or limitation applicable to an Employee, this provision overrides, with respect to anyone covered as a Retired Employee. Similarly, where the terms of this provision expressly describe a benefit, right, responsibility or limitation applicable to a Dependent of a Retired Employee, which contradicts a benefit, right, responsibility or applicable to a Dependent of an Employee, this provision overrides, with respect to anyone covered as a Dependent of a Retired Employee. Otherwise, this Plan describing the benefits, rights, responsibilities and limitations applicable to covered Employees and their Dependents apply as well to covered Retired Employees and their Dependents, respectively.

Note: The member must qualify under the provisions and requirements of the Public Education and Employee Retirement System (PEERS) or the Public School Retirement System (PSRS).

CONTRIBUTIONS TO THE PLAN

As a covered Retired Employee or covered Dependent of a Retired Employee, You may be required to make contributions to the Plan, as a condition of continuing Your coverage, that are different from the contributions made by Employees and their Dependents.

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE AS A RETIRED EMPLOYEE OR DEPENDENT OF A RETIRED EMPLOYEE

RETIRED EMPLOYEE ELIGIBILITY. In order to be eligible for coverage under the Plan under the provisions of this provision, You must be a Retired Employee. You are eligible to continue coverage as a Retired Employee if You apply for Retired Employee coverage during the 365-day window ending on Your Retirement Date, and are a Retired Employee on Your Retirement Date. If You apply for coverage as a Retired Employee during this 365-day window and are a Retired Employee on Your Retirement Date, Your coverage as a Retired Employee will begin on Your Retirement Date. If You fail to apply for coverage during this 365-day window or You are not a Retired Employee on Your Retirement Date, You will not be enrolled as a Retired Employee upon Your Retirement Date and You will be ineligible for coverage under this Plan (except under the Plan's COBRA Continuation Coverage provisions, if applicable) on and after Your Retirement Date unless You again become an Employee and again qualify for coverage under the Plan as an eligible Employee. There is no periodic "annual open enrollment period" for Retired Employees other than as described in this paragraph, and no "late enrollment" rights.

ELIGIBILITY OF A DEPENDENT OF A RETIRED EMPLOYEE. Your Dependents are eligible for coverage under this provision on the date You become eligible for Retired Employee coverage, or the date on which the Dependents become Your Dependents, whichever occurs last. However, under no circumstances may You enroll Your Dependents under this provision if You are not also enrolled under this provision. If both You and Your spouse are Retired Employees, and both are eligible for Dependent coverage, either You or Your spouse, but not both, may elect Dependent coverage for Your other eligible Dependents (e.g., Dependent Children). No person may be covered under this provision as both a Retired Employee and as a Dependent.

SPECIAL ENROLLMENT EVENTS. As a Retired Employee You are not eligible for special enrollment rights, of this Plan, attributable to the loss of other coverage or to acquisition of a new Dependent (that is, You are not entitled to a special enrollment right to enroll Yourself because You will not be an eligible Retired Employee if You do not enroll as described above, in the paragraph titled, Retired Employee Eligibility). If You are covered as a Retired Employee, however, Your Dependents are eligible for special enrollment rights.

TERMINATION OF RETIRED EMPLOYEE COVERAGE AND COVERAGE OF DEPENDENTS OF A RETIRED EMPLOYEE

RETIRED EMPLOYEE COVERAGE TERMINATION. Except as otherwise provided in this provision, Your coverage, as a Retired Employee will terminate on the earliest of the following dates:

- If You fail to remit required contributions for Your coverage when due, the date which is the end of the period for which the last timely contribution was made.
- The date You enter the military, naval or air force of any country or international organization on a full-time basis other than scheduled drills or other training not exceeding one month in any Calendar Year.
- The date You die.
- The date the Plan is terminated or coverage for Retired Employees (or the class of Retired Employees to which You belong) is terminated.
- The last day of the month in which You request Your coverage to be terminated.
- The date the Plan Sponsor determines, in its sole discretion, that You knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.

TERMINATION OF COVERAGE FOR DEPENDENT OF COVERED RETIRED EMPLOYEE. Except as provided in this provision, Your coverage as a covered Dependent of a covered Retired Employee will terminate on the earliest of the following dates:

- The date Your sponsor's (the eligible Employee's) coverage terminates.
- If required contributions for Your coverage are not remitted when due, the date which is the end of the period for which the last timely contribution was made.
- The date You enter the military, naval or air force of any country or international organization on a full-time basis other than scheduled drills or other training not exceeding one month in any Calendar Year.
- The date You cease to meet the definition of "*Dependent*," or the date Dependent coverage (for all Dependents or for Dependents of Retired Employees) is discontinued under the Plan.
- The date the Plan is terminated.
- The date the Plan Sponsor determines, in its sole discretion, that You knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.

Note: The member must qualify under the provisions and requirements of the Public Education and Employee Retirement System (PEERS) or the Public School Retirement System (PSRS).

Dependents of deceased Retired Employees are eligible for continued coverage as long as premium contributions are paid by the eligible Dependent.

COBRA CONTINUATION OF COVERAGE

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

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

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

The COBRA Administrator for this Plan is: Jefferson City Public School District

INTRODUCTION

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

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

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

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

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

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

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

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

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

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

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

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

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

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

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

COBRA NOTICE PROCEDURES

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

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

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

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

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

JEFFERSON CITY PUBLIC SCHOOL DISTRICT
315 E DUNKLIN ST
JEFFERSON CITY MO 65101

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

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

EMPLOYEE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

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

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

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

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

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

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

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

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

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

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

PAYMENT FOR CONTINUATION COVERAGE

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

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

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

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

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

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

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

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

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

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

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

- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

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

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

LENGTH OF CONTINUATION COVERAGE

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

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

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

  - Employee's death.
  - Employee's divorce or legal separation.
  - Former Employee becomes enrolled in Medicare.
  - A Dependent Child no longer being a Dependent as defined in the Plan.

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

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

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

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

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

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

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

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

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

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

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

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

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

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

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

EARLY TERMINATION OF COBRA CONTINUATION

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

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

- The required contribution for the Qualified Beneficiary's coverage is not paid on time.

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

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

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

- Termination for cause, such as submitting fraudulent claims.

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

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

DEFINITIONS

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

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

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

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

IF YOU HAVE QUESTIONS

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

The Plan Administrator:
JEFFERSON CITY PUBLIC SCHOOL DISTRICT
315 E DUNKLIN ST
JEFFERSON CITY MO 65101

The COBRA Administrator

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

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

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

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

USERRA NOTICE AND ELECTION

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

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

PAYMENT

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

EXTENDED COVERAGE RUNS CONCURRENT

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

PROVIDER NETWORK

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

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

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

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

  0L – UnitedHealthcare Choice Plus

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim than they would for an Out-of-Network claim.

  XZ – First Health Shared Savings

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

The program for Transplant Services at Designated Transplant Facilities is:

OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by an Out-of-Network provider. When Non-Network charges are covered in accordance with Network benefits, the charges are still subject to the Usual and Customary charge limitations. The following exceptions may apply:

- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- Covered Services provided by an Emergency room Physician will be payable at the In-Network level of benefits when provided at an In-Network Hospital. **(Applies to Benefit Plan(s) 001, 002)**

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

TRANSITIONAL CARE

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

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

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

COVERED MEDICAL BENEFITS

(Applies to Benefit Plan(s) 001, 002) This Plan provides coverage for the following covered benefits if services are authorized by a Physician and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

(Applies to Benefit Plan(s) 003, 004) This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

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

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

2. **Abortions:** If a Physician states in writing that:

   - The mother's life would be in danger if the fetus were to be carried to term, or
   - Abortion is medically indicated due to complications with the pregnancy.

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

4. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped and used only to transport the sick and injured to the nearest medically appropriate Hospital.

5. **Anesthetics and their Administration.**

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

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

8. **Autism Spectrum Disorders (ASD) Treatment**, when Medical Necessity is met.

   (ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome and Pervasive Developmental Disorders).

   ASD Treatment may include any of the following services: Diagnosis and Assessment; Proposed treatment by type, frequency and duration of treatment; Goals; Psychological, Psychiatric, and Pharmaceutical (medication management) care; Speech Therapy, Occupational Therapy, and Physical Therapy ; or Applied Behavioral Analysis (ABA) Therapy.

   Treatment is prescribed and provided by a licensed healthcare professional practicing within the scope of their license (if ABA therapy, preferably a Board Certified Behavior Analyst, BCBA).

If ABA Therapy meets Medical Necessity, frequency and duration will be subject to current UMR guidelines, for example ABA treatment up to 25 hours per week for 3-6 months. Treatment plans specific to ABA Therapy with goals-progress and updates are required no more than every 6 months for review of ongoing therapy to evaluate continued Medical Necessity unless the individual's treating physician/psychologist agrees that more frequent review is required.

Treatment is subject to all other plan provisions as applicable (such as Prescription benefit coverage, Behavioral/Mental Health coverage and/or coverage of therapy services).

Does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Investigational/Experimental or Unproven, custodial, nutrition-diet supplements, educational or services that should be provided through the school district).

9. **Breast Pumps** and related supplies. Coverage is subject to Medical Necessity as defined by this Plan. Contact the Plan regarding limits on frequency, duration, or type of equipment that is covered.

10. **Breastfeeding Support, Supplies and Counseling** in conjunction with each birth. Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.

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

12. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (See Glossary of Terms) as well as a result of an Illness or Injury.

13. **Cardiac Rehabilitation** programs are covered if referred by a Physician, for patients who have:

    - had a heart attack in the last 12 months; or
    - had coronary bypass surgery; or
    - a stable angina pectoris.

    Services covered include:

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

14. **Cataract or Aphakia Surgery** as well as protective lenses following such procedure.

15. **Chiropractic Treatment (Applies to Benefit Plan(s) 001, 002)** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography, and when Medically Necessary for treatments for musculoskeletal conditions. Refer to Maintenance Therapy under the General Exclusions section of this SPD.

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

17. **Cleft Palate And Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes oral surgery and pre-graft palatal expander when Medically Necessary.

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

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

20. **Counseling Services** in connection with marriage or if Medically Necessary.

21. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants. Treatment must be completed within 6 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

22. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling.

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

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

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

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

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

26. Extended Care Facility Services for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. Covered Person must give prior authorization for services in advance. (Refer to the Care Management section of this SPD). The following benefits are covered:

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

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

- Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
- Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
- Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.
- Covered charges do not include Palliative Foot Care.

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

29. **Genetic Testing** when Medically Necessary (see below) after prior authorization.

    Genetic Testing MUST meet the following requirements:

    The test is not considered Experimental or Investigational. The test is performed by a CLIA-certified laboratory. The test result will directly impact/influence the disease treatment of the covered member. In some cases, testing is accompanied by pretest and posttest counseling.

    And must meet at least one of the following:

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

    Generally, genetic testing is not covered for:

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

30. **Hearing Services** include exams, tests, services and supplies including Preventive Care, or to diagnose and treat a medical condition.

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

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

    - **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **(Applies to Benefit Plan(s) 001, 002) Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietician.
    - **(Applies to Benefit Plan(s) 001, 002) Bereavement Counseling**: Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist. These services must be furnished within six months of death.
    - **(Applies to Benefit Plan(s) 003, 004) Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include the services of a Physician or Qualified physical or occupational therapist, or nutrition counseling services provided by or under the supervision of a Qualified dietician.
    - **(Applies to Benefit Plan(s) 003, 004) Bereavement Counseling** benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and bundled with other hospice charges. Counseling services must be given by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. These services must be furnished within six months of death.

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

33. **Hospital Services (Includes Inpatient Services, Surgical Centers And Birthing Centers).** The following benefits are covered:

    - Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only when Medical Necessity is met. If the Hospital has no semi-private rooms, the Plan will allow the private room rate subject to Usual and Customary charges or the Negotiated Rate, whichever is applicable.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

34. **Hospital Services (Outpatient).**

35. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

36. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary, alleviates the symptoms, slows the harm, or maintains the current health status of the Covered Person.

    Infertility Treatment does not include Genetic Testing. (See General Exclusions for details).

37. **Laboratory Or Pathology Tests And Interpretation Charges** for covered benefits.

38. **Manipulations: (Applies to Benefit Plan(s) 003, 004)** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

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

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

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

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

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

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

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

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

    Expenses for the covered newborn will be processed under the mother's benefits until the mother is discharged from the Hospital following the delivery. If the covered newborn needs to stay in the Hospital longer than the mother following the delivery, those charges will be processed under the newborn's benefits subject to the Deductible and other Plan provisions, including HIPAA Special Enrollment.

44. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings) provided the feedings are prescribed by a Physician, and are the sole source of nutrition.

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

46. **Oral Surgery** includes:

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

47. **Orthognathic, Prognathic And Maxillofacial Surgery** when Medically Necessary.

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

49. **Oxygen And Its Administration.**

50. **Pharmacological Medical Case Management** (Medication management and lab charges).

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

52. **Physician Services** for covered benefits.

53. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

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

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

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

    - Evidence-based items or services that have in affect 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;
- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- Well-woman Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-woman visit should, where appropriate, include following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act.

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

  Please visit the following links for additional information:

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

56. **Private Duty Nursing Services** when care is required 24 hours a day and for Medically Necessary purposes.

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

    - Due to the growth or development of a Dependent Child; or
    - When necessary because of a change in the Covered Person's physical condition; or
    - Because of deterioration caused from normal wear and tear.

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

58. **Qualifying Clinical Trials (Applies to Benefit Plan(s) 003, 004)** as defined below, including routine patient care costs as defined below Incurred during participation in a Qualifying Clinical Trial for the treatment of:

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

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

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

    Routine patient care costs for Qualifying Clinical Trials may include:

    - Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;

- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

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

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

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

59. **Radiation Therapy and Chemotherapy.**

60. **Radiology and Interpretation Charges.**

61. **Reconstructive Surgery** includes:

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

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

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

64. **Sleep Disorders** if Medically Necessary.

65. **Sleep Studies.**

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

67. **Sterilizations (Voluntary).**

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

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

70. **Surrogate Parenting and Gestational Carrier Services:** Plan will cover the surrogate's pregnancy and maternity charges incurred by a Covered Person acting as a surrogate parent as long as there is no contract or any type of payment received for the surrogacy services.

71. **Temporomandibular Joint Disorder (TMJ) Services** includes:

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

    This does not cover orthodontic services.

72. **Therapy Services (Applies To Benefit Plan(s) 001, 002):** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist.
    - **Physical therapy** by a Qualified physical therapist.
    - **Respiratory therapy** by a Qualified respiratory therapist.
    - **Aquatic therapy** by a Qualified physical therapist.
    - **Speech therapy** by a Qualified speech therapist including therapy for stuttering due to a neurological disorder.

73. **Therapy Services (Applies to Benefit Plan(s) 003, 004):** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist (OT), or other Qualified Provider, if applicable.
    - **Physical therapy** by a Qualified physical therapist (PT), or other Qualified Provider, if applicable.
    - **Respiratory therapy** by a Qualified respiratory therapist (RT), or other Qualified Provider, if applicable.
    - **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
    - **Speech therapy** by a Qualified speech therapist (ST), or other Qualified Provider, if applicable, including therapy for stuttering due to a neurological disorder.

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

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

76. **Wigs, Toupees, Hairpieces** for cancer treatment only.

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

REAL APPEAL PROGRAM

This Plan provides the Real Appeal program which represents a practical solution for weight-related conditions, with the goal of helping people at risk from obesity-related diseases and those who want to maintain a healthy lifestyle. This program is designed to support individuals over the age of 18. This intensive, multi-component behavioral intervention provides a 52-week virtual approach that includes one-on-one coaching and online group participation with supporting video content, delivered by a live, virtual coach. The experience will be personalized for each individual though an introductory call.

This program will be individualized and may include, but not limited to, the following:

- Online support and self-help tools: Personal one-on-one coaching, group support sessions, including integrated telephonic support, and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers, and strategies to maintain changes.
- Behavioral change guidance and counseling by a specially trained health coach for clinical weight loss.

Participation is completely voluntary and without any additional charge or cost share. There are no Co-pays, Participation, or Deductibles that need to be met when services are received as part of the Real Appeal Program. If You would like to participate, or if You would like any additional information regarding the program, visit the Real Appeal website at member.realappeal.com.

HOME HEALTH CARE BENEFITS

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

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

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- **(Applies to Benefit Plan(s) 001, 002)** Nutrition counseling provided by or under the supervision of a registered dietician.
- **(Applies to Benefit Plan(s) 001, 002)** Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- **(Applies to Benefit Plan(s) 003, 004)** Nutrition counseling provided by or under the supervision of a Qualified dietician, or other Qualified Provider, if applicable.
- **(Applies to Benefit Plan(s) 003, 004)** Physical, occupational, respiratory and speech therapy provided by or under the supervision of a Qualified therapist, or other Qualified Provider, if applicable.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

(Applies to Benefit Plan(s) 001, 002) A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Clinical Eligibility for Coverage is met) or a single visit by a therapist or a registered dietician.

(Applies to Benefit Plan(s) 003, 004) A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

EXCLUSIONS

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

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

TRANSPLANT BENEFITS

Refer to the Care Management section of this SPD for prior authorization requirements

DEFINITIONS

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

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

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

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

Stem Cell Transplant includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

BENEFITS

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

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

COVERED EXPENSES

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

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

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

Benefits are payable for the following transplants:

- Kidney.
- Kidney/Pancreas.
- Pancreas, if the transplant meets the criteria determined by Care Management.
- Liver.
- Heart.

- Heart/Lung.
- Lung.
- Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions.
- Small Bowel.

SECOND OPINION

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

TRANSPLANT EXCLUSIONS

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

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

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

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

- Transplants considered Experimental, Investigational or Unproven.

- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured. Exceptions, which will require additional review for Medical Necessity, include: diagnoses of squamous cell and basal cell carcinoma of the skin and hepatocellular carcinoma.

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

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

PRESCRIPTION DRUG BENEFITS

Administered by OptumRx – Direct

Benefit Plan(s) 001, 002

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

INTRODUCTION

If You elect coverage under a medical Plan option offered by JEFFERSON CITY PUBLIC SCHOOL DISTRICT, You automatically receive Prescription drug benefits through Catamaran, an OptumRx company. Your contribution to the cost of Your Prescription drug coverage is included in the premium You pay for medical Plan coverage. The Prescription drug coverage provides coverage for both retail and mail order Prescriptions.

You should review the SPD or contact OptumRx at (877) 629-3117 or www.optumrx.com/mycatamaranrx for more information or if You have coverage questions.

HOW THE PLAN WORKS

With the Prescription drug coverage, the amount that You pay is based on whether the drug is generic, a preferred brand, or a non-preferred brand and whether You are purchasing the drug at a retail pharmacy or through mail order.

With mail order, You will save money because You pay a two (2) month Co-pay for a three (3) month (90-day) supply of a Prescription. The mail order Co-pay is less than the amount You would pay if You filled that Prescription at a retail pharmacy three (3) times. Mail order is ideal for maintenance medications that You take on an ongoing basis.

There is a four (4) tier cost schedule for Your Prescriptions. Ranging from the least expensive to the most expensive, the tiers are:

- Generic drugs
- Preferred brand drugs
- Non-preferred brand drugs
- Specialty

PRESCRIPTION DRUG DEFINITIONS

Drug Type	Definition
Generic	A drug that is equivalent to a brand name Prescription. By law, a generic must contain the same active ingredients and chemical composition as brand name drugs. Therefore, taking a generic drug should treat the condition the same as the brand, but the Prescription can be obtained at a lower cost.
Preferred Brand	Brand name medications that are on the Premium Formulary.
Non-Preferred Brand	Brand name medications that are not on the Premium Formulary

FORMULARY

The Prescription Plan utilizes a four tier formulary. A formulary is a list of prescribed medications, including both generic and brand name drugs, that have proven to be both clinically and cost effective. Prescriptions on the formulary are categorized into four tiers and those tiers determine Your cost for a particular medication. There are preferred products in every therapeutic class in the formulary. Some Prescriptions are "excluded" from the formulary, and these medications are not covered under the Prescription Plan.

SCHEDULE OF BENEFITS

Prescription Plan Benefit Design if enrolled under the JEFFERSON CITY PUBLIC SCHOOL DISTRICT		
	Retail (up to a 30 day supply)	Mail Order (up to a 90 day supply)
Generic	$10 Co-pay	$20 Co-pay
Preferred Brand	$30 Co-pay	$60 Co-pay
Non-Preferred Brand	$50 or Member Pays the Difference	$100 or Member Pays the Difference
Specialty Medications	**Exclusive through Briova Specialty Program** Less than $1000 = $75 Co-pay More than $1000 = $125 Co-pay	

RETAIL PHARMACY SERVICE

OptumRx has a national network of retail pharmacies. Use a local participating pharmacy for a Prescription drug that You need immediately and for which You will require no more than a 30-day supply.

The cost for retail Prescriptions may change annually. For 2017, the Co-pays of retail Prescriptions are:

- $10 for generic;
- $30 for preferred brand;
- $50 for non-preferred brand or Member Pays the Difference for brand name drugs that have a generic equivalent.

To obtain a Prescription from a participating pharmacy, present Your OptumRx Prescription drug card. The pharmacist will fill Your Prescription and You will pay the applicable Co-pay.

There are no claim forms to fill out unless You purchase a drug from a non-participating pharmacy.

Below is a list of drugs which are not covered under the Retail Pharmacy Program. If You or Your doctor have a question about whether or not a drug is covered, please call OptumRx at (877) 629-3117.

EXCLUSIONS

The following drugs/supplies are excluded:

- Non-Federal Legend Drugs;
- Allergy Serum (covered through the medical Plan)
- Therapeutic devices or appliances;
- Certain Compound medications;
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual; and
- Drugs that are excluded from the formulary

MAIL ORDER SERVICE

The Mail Order Service allows You to order maintenance Prescription drugs (up to a 90-day supply) through the mail. For 2017, the cost of mail order Prescriptions are:

- $20 for generic;
- $60 for preferred brand;
- $100 for non-preferred or Member Pays the Difference for brand name drugs that have a generic equivalent.

To use the Mail Order Service, log onto OptumRx website at www.optumrx.com/mycatamaranrx or call OptumRx. You will need to submit a Prescription for a 90 day supply, and payment to OptumRx. (You can set up a credit card to be charged for future refills). As a reminder, You pay a two (2) month Co-pay for a three (3) month (90-day) supply. Your Prescription is delivered to Your home, postage-paid, along with the instructions for refills.

If You are receiving long-term medication for the first time, You should ask Your doctor to provide two (2) Prescriptions; one to be filled at Your local participating pharmacy for the initial 30-day period, and a second to be submitted through the Mail Order Service for a 90 day supply. Or, upon request, OptumRx will contact Your retail pharmacy for a copy of Your Prescription.

Below is a list of drugs which are not covered under the Mail Order Program. If You or Your doctor have a question as to whether or not a drug is covered, please call OptumRx at (877) 629-3117.

EXCLUSIONS

The following drugs/supplies are excluded:

- Non-Federal Legend Drugs;
- Allergy Serum(covered through the medical Plan);
- Therapeutic devices or appliances;
- Certain compound medications; and
- Drugs labeled “Caution-limited by Federal law to investigational use,” or experimental drugs, even though a charge is made to the individual; and
- Drugs that are excluded in the formulary.

MEMBER PAYS THE DIFFERENCE

If You or Your Physician choose a brand name drug that has a generic equivalent, You will pay the difference between the cost of the brand name drug and the generic drug, plus the generic Co-pay. This additional cost will apply even if Your doctor has indicated “Dispense As Written” (DAW) on Your Prescription. To find the generic equivalent for the brand name drug You are taking, You may discuss this with Your doctor or log in at www.optumrx.com/mycatamaranrx and select Drug Lookup. When You enter the name of Your medication this online tool will provide You with personalized cost-savings opportunities specific to Your Prescriptions and Prescription drug coverage. You may also call OptumRx at (877) 629-3117, 24 hours a day, 7 days a week. You will need to have Your doctor write a new Prescription for the generic equivalent.

There is a coverage appeals process for clinical exceptions through OptumRx if You had an adverse reaction, allergy or sensitivity to generic equivalent, if You had a failed trial with generic equivalent, or if transitioning to a generic equivalent could result in destabilization or unnecessary risk to You. Your provider will need to file an appeal directly with OptumRx. If the appeal is approved, You will only be responsible to pay the preferred brand Co-pay. To initiate the appeal, Your doctor should call OptumRx at (877) 629-3117, and request to speak with the Prior Authorization area.

FORMULARY CLINICAL EXCEPTIONS

If Your Physician prescribes a non-preferred or excluded medication due to negative clinical results, such as an allergic reaction, that You experienced when using a preferred or generic medication, You may be eligible for coverage through a clinical exception. Your provider will need to request a Prior Authorization from OptumRx. Your doctor should call OptumRx at (877) 629-3117, and request to speak with the Prior Authorization area. If the Prior Authorization is approved for a non-preferred drug, You will pay the preferred drug Co-pay. If the Prior Authorization is approved for an excluded drug, You will pay the non-preferred drug Co-pay.

PREVENTIVE ITEMS AND SERVICES

Certain Prescriptions intended to prevent Illness and disease, as well as contraceptives, are covered at 100%. This applies to generic and certain single-source brand drugs as well as some over-the-counter (OTC) drugs (Prescription required). The list of preventive drugs should be used as a guide, and is not a comprehensive list. This list is subject to change as Affordable Care Act (ACA) guidelines are updated or modified. You may contact OptumRx for more information and updates.

SPECIALTY MEDICATIONS

Specialty medications are not covered at a retail pharmacy and may be purchased only through OptumRx Specialty Pharmacy, Briova. Contact Briova at (855) 427-4682 to access these drugs.

OPTUMRX PROGRAMS

JEFFERSON CITY PUBLIC SCHOOL DISTRICT participates in prior authorization, step therapy, quantity duration, and compound medication programs. The conditions or drug categories that may require prior authorization, step therapy and/or quantity duration includes, but are not limited to the following:

- Acne;
- Allergy and asthma;
- Anti-influenza agents;
- CNS stimulants/Strattera/amphetamines;
- Depression therapy;
- Erectile dysfunction therapy;
- Multiple Sclerosis therapy;
- Narcolepsy;
- Proton pump inhibitors;
- Pulmonary arterial hypertension therapy;
- RSV agents (respiratory syncytial virus);
- Rheumatoid arthritis.

To determine if a drug requires prior authorization, step therapy, and quantity during review, You may contact OptumRx at (877) 629-3117.

An OptumRx pharmacist may need to speak with the prescribing Physician to ensure that the patient meets the criteria for the Prescription prescribed. In addition, the quantity of some Prescription medications dispensed may be limited based on FDA regulations in order to ensure patient safety. If Your Physician deems it necessary for Your care and treatment, the Physician may appeal these limits directly with OptumRx. You or Your provider may check with OptumRx to verify covered Prescription drugs, any quantity and/or age limits, prior authorization or other requirements of the Plan.

OTHER IMPORTANT INFORMATION

JEFFERSON CITY PUBLIC SCHOOL DISTRICT reserves the rights to amend, suspend, or terminate its Prescription drug coverage in whole or in part, at any time and for any reason. JEFFERSON CITY PUBLIC SCHOOL DISTRICT has full authority and discretion to construe, interpret and administer its Prescription drug coverage. The Prescription drug coverage is unfunded, and no employee or dependent shall have any right to, or interest in, any assets of JEFFERSON CITY PUBLIC SCHOOL DISTRICT which may be applied by JEFFERSON CITY PUBLIC SCHOOL DISTRICT to the payment of benefits. Neither the establishment of the Prescription drug coverage, nor the provision of benefits to any person, shall be construed as giving an employee the right to be retained in the service of JEFFERSON CITY PUBLIC SCHOOL DISTRICT.

CLAIMS PROCEDURE

You must use and exhaust the administrative claims and appeals procedure set forth below before bringing a suit in either state or federal court. Similarly, failure to follow the prescribed procedures in a timely manner will also cause You to lose Your right to sue regarding an Adverse Benefit Determination.

A pre-service claim is a request for coverage of a medication when Your coverage requires You to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below) You will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim, provided You have submitted sufficient information to decide Your claim. A post-service claim is a request for coverage or reimbursement when You have already received the medication. For post-service claims, You will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

If sufficient information to complete the review has not been provided, You will be notified that the claim is missing information within 15 days from receipt of Your pre-service claim and 30 days from receipt of Your post-service claim. You will have 45 days to provide the information. Once all of the needed information is received within the 45-day time-frame, You will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If You don't provide the needed information within the 45-day period, Your claim is considered "deemed" denied and You have the right to appeal as described below.

If Your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes and any additional information needed to perfect Your claim. You have the right to a full and fair impartial review of Your claim. You have the right to review Your file and the right to receive, upon request and at no charge, the information used to review Your claim. If You do not speak English well and require assistance in Your native language to understand the letter or Your claims and appeals rights, please call (800)-626-0072. In addition, You may also have the right to request a written translation of Your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If You are not satisfied with the decision on Your claim (or Your claim is deemed denied), You have the right to appeal as described below.

URGENT CLAIMS (EXPEDITED REVIEWS)

An urgent care claim is defined as a request for treatment when, in the opinion of Your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize Your life or health or Your ability to regain maximum function or would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of Your claim. 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 provided there is sufficient information to decide the claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, You will be notified within 24 hours after receipt of Your claim that information is necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. If You don't provide the needed information within the 48-hour period, Your claim is considered "deemed" denied and You have the right to appeal as described below.

If Your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes and any additional information needed to perfect Your claim. You have the right to a full and fair impartial review of Your claim. You have the right to review Your file and the right to receive, upon request and at no charge, the information used to review Your claim. If You do not speak English well and require assistance in Your native language to understand the letter or Your claims and appeals rights, please call (800) 626-0072. In addition, You may also have the right to request a written translation of Your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If You are not satisfied with the decision on Your claim (or Your claim is deemed denied), You have the right to appeal as described below.

NON-URGENT APPEAL

If You are not satisfied with the decision regarding Your benefit coverage or You receive an Adverse Benefit Determination following a request for coverage of a Prescription benefit claim (including a claim considered "deemed" denied because missing information was not timely submitted), You have the right to appeal the Adverse Benefit Determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by You or Your authorized representative (such as Your Physician). To initiate an appeal for coverage, provide in writing:

Your name;
Member ID;
Phone number;
The Prescription drug for which benefit coverage has been denied; and
Any additional information that may be relevant to Your appeal.

This information should be mailed to OptumRx, c/o Appeals Coordinator, CA106-0286, 3515 Harbor Blvd, Costa Mesa, CA 92626 or fax to (866) 511-2202. A decision regarding Your appeal will be sent to You within 15 days of receipt of Your written request for pre-service claims or 30 days of receipt of Your written request for post-service claims. If Your appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes and any additional information needed to perfect Your claim. You have the right to a full and fair impartial review of Your claim. You have the right to review Your file and the right to receive, upon request and at no charge, the information used to review Your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to You if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of Your claim). If You do not speak English well and require assistance in Your native language to understand the letter or Your claims and appeals rights, please call (800) 626-0072. In addition, You may also have the right to request a written translation of Your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If You are not satisfied with the coverage decision made on Your appeal, You may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by You or Your authorized representative (such as Your Physician). To initiate a second level appeal, provide in writing:

Your name;
Member ID;
Phone number;
The Prescription drug for which benefit coverage has been denied; and
Any additional information that may be relevant to Your appeal.

This information should be mailed to OptumRx, c/o Appeals Coordinator, CA106-0286, 3515 Harbor Blvd, Costa Mesa, CA 92626 or fax to (866) 511-2202. A decision regarding Your request will be sent to You in writing within 15 days of receipt of Your written request for pre-service claims or 30 days of receipt of Your written request for post-service claims. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered in relation to Your appeal, the provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes. You have the right to a full and fair impartial review of Your claim. You have the right to review Your file, the right to receive, upon request and at no charge, the information used to review Your second level appeal, and present evidence and testimony as part of Your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to You if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of Your claim). If You do not speak English well and require assistance in Your native language to understand the letter or Your claims and appeals rights, please call (800) 626-0072. In addition, You may also have the right to request a written translation of Your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If new information is received and considered or relied upon in the review of Your second level appeal, such information will be provided to You together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on Your second level appeal is final and binding.

If Your second level appeal is denied and You are not satisfied with the decision of the second level appeal (i.e., Your “final Adverse Benefit Determination”) or Your initial benefit denial notice or any appeal denial notice (i.e., any “Adverse Benefit Determination notice” or “final Adverse Benefit Determination”) does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), You have the right to bring a civil action under ERISA section 502(a).

In addition, for cases involving medical judgment or rescission, if Your second level appeal is denied and You are not satisfied with the decision of the second level appeal (i.e., Your “final Adverse Benefit Determination”) or Your initial benefit denial notice or any appeal denial notice (i.e., any “Adverse Benefit Determination notice” or “final Adverse Benefit Determination”) does not contain all of the information required under ERISA, You have the right to an independent review by an external review organization. Details about the process to appeal Your claim and initiate an external review will be described in any notice of an Adverse Benefit Determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the Prescription drug coverage (e.g., Prescription drug coverage only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

URGENT APPEAL (EXPEDITED REVIEW)

You have the right to request an urgent appeal of an Adverse Benefit Determination (including a claim considered denied because missing information was not timely submitted) if Your situation is urgent. An urgent situation is one where in the opinion of Your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize Your life or health or Your ability to regain maximum function or would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of Your claim. To initiate an urgent claim or appeal request, You or Your Physician (or other authorized representative) must call (800) 626-0072 or fax the request to (866) 511-2202. Claims and appeals submitted by mail will not be considered for urgent processing unless and until You call or fax and request that Your claim or appeal be considered for urgent processing. 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. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered in relation to Your appeal, the provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes. You have the right to a full and fair impartial review of Your claim. You have the right to review Your file, the right to receive, upon request and at no charge, the information used to review Your appeal, and present evidence and testimony as part of Your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to You if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of Your claim). If You do not speak English well and require assistance in Your native language to understand the letter or Your claims and appeals rights, please call (800) 626-0072. In addition, You may also have the right to request a written translation of Your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If new information is received and considered or relied upon in the review of Your appeal, such information will be provided to You together with an opportunity to respond prior to issuance of any final adverse determination. The decision made on Your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

If Your appeal is denied and You are not satisfied with the decision of the appeal (i.e., Your “final Adverse Benefit Determination”) or any appeal denial notice (i.e., “Adverse Benefit Determination notice” or “final Adverse Benefit Determination”) does not contain all of the information required under ERISA, You have the right to bring a civil action under ERISA section 502(a).

In addition, for cases involving medical judgment or rescission, if Your appeal is denied and You are not satisfied with the decision (i.e., Your “final Adverse Benefit Determination”) or Your initial benefit denial notice or any appeal denial notice (i.e., Your “Adverse Benefit Determination” or “final Adverse Benefit Determination”) does not contain all of the information required under ERISA, You have the right to an independent review by an external review organization.

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize Your life or health or Your ability to regain maximum function, You also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided You file Your request for an internal appeal of the Adverse Benefit Determination at the same time You request the independent external review. If You are not satisfied or You do not agree with the determination of the external review organization, You have the right to bring a civil action under ERISA section 502(a).

Details about the process to appeal Your claim and initiate an external review will be described in any notice of an Adverse Benefit Determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the Prescription drug coverage (e.g., Prescription drug coverage only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

EXTERNAL REVIEW PROCEDURES

The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the Prescription drug coverage (e.g., Prescription drug coverage only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to Your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, You must exhaust the internal claim review process described above, unless Your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or Your appeal is urgent. In the case of an urgent appeal, You can submit Your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively You can submit Your urgent appeal for the external independent review after You have completed the internal appeal process.

To file for an independent external review, Your external review request must be received within 4 months of the date of the Adverse Benefit Determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should be mailed or faxed to: OptumRx, c/o Appeals Coordinator, CA106-0286, 3515 Harbor Blvd, Costa Mesa, CA 92626 or fax to (866) 511-2202.

NON-URGENT EXTERNAL REVIEW

Once You have submitted Your external review request, Your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and You will be notified within 1 business day of the decision.

If Your request is eligible to be forwarded to an IRO, Your request will randomly be assigned to an IRO and Your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify You in writing that it has received the request for an external review and if the IRO has determined that Your claim involves medical judgment or rescission, the letter will describe Your right to submit additional information within 10 business days for consideration to the IRO. Any additional information You submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review Your claim within 45 calendar days and send You, the Prescription drug coverage sponsor, and OptumRx written notice of its decision. If You are not satisfied or You do not agree with the decision, You have the right to bring civil action under ERISA section 502(a). If the IRO has determined that Your claim does not involve medical judgment or rescission, the IRO will notify You in writing that Your claim is ineligible for a full external review and You have the right to bring civil action under ERISA section 502(a).

URGENT EXTERNAL REVIEW

Once You have submitted Your urgent external review request, Your claim will immediately be reviewed to determine if You are eligible for an urgent external review. An urgent situation is one where in the opinion of Your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize Your life or health or Your ability to regain maximum function or would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of Your claim.

If You are eligible for urgent processing, Your claim will immediately be reviewed to determine if Your request is eligible to be forwarded to an IRO, and You will be notified of the decision. If Your request is eligible to be forwarded to an IRO, Your request will randomly be assigned to an IRO and Your appeal information will be compiled and sent to the IRO. The IRO will review Your claim within 72 hours and send You, the Prescription drug coverage sponsor, and OptumRx written notice of its decision. If You are not satisfied or You do not agree with the decision, You have the right to bring civil action under ERISA section 502(a).

PRESCRIPTION DRUG BENEFITS

Administered by OptumRx – Direct

Benefit Plan(s) 003, 004

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

INTRODUCTION

If You elect coverage under a medical Plan option offered by JEFFERSON CITY PUBLIC SCHOOL DISTRICT, You automatically receive Prescription drug benefits through Catamaran, an OptumRx company. You contribution to the cost of Your Prescription drug coverage is included in the premium You pay for medical Plan coverage. The Prescription drug coverage provides coverage for both retail and mail order Prescriptions.

If You elect coverage under the JEFFERSON CITY PUBLIC SCHOOL DISTRICT, Your coverage will be integrated with Your medical Plan coverage, and You will be required to meet the JEFFERSON CITY PUBLIC SCHOOL DISTRICT's Plan year deductible prior receiving coverage.

You should review the SPD or contact OptumRx at (877) 629-3117 or www.optumrx.com/mycatamaranrx for more information or if You have coverage questions.

HOW THE PLAN WORKS

With the Prescription drug coverage, the amount that You pay is based on whether the drug is generic, a preferred brand, or a non-preferred brand and whether You are purchasing the drug at a retail pharmacy or through mail order.

With the exception of preventive items and services and of IRS-designated drugs which treat chronic conditions, coverage is provided only after You have met the required deductible with Your medical and Prescription expenses.

With mail order, You will save money because You pay a two (2) month Co-pay for a three (3) month (90-day) supply of a Prescription. The mail order Co-pay is less than the amount You would pay if You filled that Prescription at a retail pharmacy three (3) times. Mail order is ideal for maintenance medications that You take on an ongoing basis.

There is a four (4) tier cost schedule for Your Prescriptions. Ranging from the least expensive to the most expensive, the tiers are:

- Generic drugs.
- Preferred brand drugs.
- Non-preferred brand drugs.
- Specialty.

PRESCRIPTION DRUG DEFINITIONS

Drug Type	Definition
Generic	A drug that is equivalent to a brand name Prescription. By law, a generic must contain the same active ingredients and chemical composition as brand name drugs. Therefore, taking a generic drug should treat the condition the same as the brand, but the Prescription can be obtained at a lower cost.

Preferred Brand	Brand name medications that are on the Premium Formulary.
Non-Preferred Brand	Brand name medications that are not on the Premium Formulary

FORMULARY

The Prescription Plan utilizes a four tier formulary. A formulary is a list of prescribed medications, including both generic and brand-name drugs, that have proven to be both clinically and cost effective. Prescriptions on the formulary are categorized into four tiers and those tiers determine Your cost for a particular medication. There are preferred products in every therapeutic class in the formulary. Some Prescriptions are "excluded" from the formulary, and these medications are not covered under the Prescription Plan.

SCHEDULE OF BENEFITS

Prescription Plan Benefit Design if enrolled under the JEFFERSON CITY PUBLIC SCHOOL DISTRICT		
	Retail (up to a 30 day supply)	Mail Order (up to a 90 day supply)
Generic	$10 Co-pay	$20 Co-pay
Preferred Brand	$30 Co-pay	$60 Co-pay
Non-Preferred Brand	$50 or Member Pays the Difference	$100 or Member Pays the Difference
Specialty Medications	Exclusive through Briova Specialty Program Less than $1000 = $75 Co-pay More than $1000 = $125 Co-pay	

Deductible: Combined Prescription and medical - $1500 individual/$3000 family.
Out-of-Pocket Maximum (OPM): Combined Prescription and medical - $3000 individual/$6000 family. Once the member and/or family OPM is satisfied, no additional Co-pays are required for the remainder of the Plan year. Amounts paid for the Member Pays the Difference Program" and the "Home Delivery Incentive Program" do not count towards the OPM.

RETAIL PHARMACY SERVICE

OptumRx has a national network of retail pharmacies. Use a local participating pharmacy for a Prescription drug that You need immediately and for which You will require no more than a 30-day supply.

The cost for retail Prescriptions may change annually. For 2017, the Co-pays of retail Prescriptions are:

- $10 for generic.
- $30 for preferred brand.
- $50 for non-preferred brand or Member Pays the Difference for brand name drugs that have a generic equivalent.

To obtain a Prescription from a participating pharmacy, present Your OptumRx Prescription drug card. The pharmacist will fill Your Prescription and You will pay the applicable Co-pay.

There are no claim forms to fill out unless You purchase a drug from a non-participating pharmacy.

Below is a list of drugs which are not covered under the Retail Pharmacy Program. If You or Your doctor have a question about whether or not a drug is covered, please call OptumRx at (877) 629-3117.

EXCLUSIONS

The following drugs/supplies are excluded:

- Non-Federal Legend Drugs;
- Allergy Serum (covered through the medical Plan);
- Therapeutic devices or appliances;
- Certain Compound medications;
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual; and
- Drugs that are excluded from the formulary.

MAIL ORDER SERVICE

The Mail Order Service allows You to order maintenance Prescription drugs (up to a 90-day supply) through the mail. For 2017 the cost of mail order Prescriptions are:

- $20 for generic;
- $60 for preferred brand;
- $100 for non-preferred or Member Pays the Difference (see page 5) for brand name drugs that have a generic equivalent.

To use the Mail Order Service, log onto OptumRx website at www.optumrx.com/mycatamaranrx or call OptumRx. You will need to submit a Prescription for a 90-day supply, and payment to OptumRx (You can set up a credit card to be charged for future refills). As a reminder, You pay a two (2) month co-pay for a three (3) month (90-day) supply. Your Prescriptions are delivered to Your home, postage-paid, along with instructions for refills.

If You are receiving long-term medication for the first time, You should ask Your doctor to provide two (2) Prescriptions; one to be filled at Your local participating pharmacy for the initial 30-day period, and a second to be submitted through the Mail Order Service for a 90-day supply. Or, upon request, OptumRx will contact Your retail pharmacy for a copy of Your Prescription.

Below is a list of drugs which are not covered under the Mail Order Program. If You or Your doctor have a question as to whether or not a drug is covered, please call OptumRx at (877) 629-3117.

EXCLUSIONS

The following drugs/supplies are excluded:

- Non-Federal Legend Drugs;
- Allergy Serum(covered through the Medical Plan);
- Therapeutic devices or appliances;
- Certain Compound Medications;
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual and
- Drugs that are excluded in the formulary.

MEMBER PAYS THE DIFFERENCE

If You or Your Physician choose a brand name drug that has a generic equivalent, You will pay the difference between the cost of the brand name drug and the generic drug, plus the generic co-pay. This additional cost will apply even if Your doctor has indicated "Dispense As Written" (DAW) on Your Prescription. To find the generic equivalent for the brand name drug You are taking, You may discuss this with Your doctor or log in at www.optumrx.com/mycatamaranrx and select Drug Lookup. When You enter the name of Your medication this online tool will provide You with personalized cost-savings opportunities specific to Your Prescriptions and Prescription drug coverage. You may also call OptumRx at (877) 629-3117, 24 hours a day, 7 days a week. You will need to have Your doctor write a new Prescription for the generic equivalent.

There is a coverage appeals process for clinical exceptions through OptumRx if You had an adverse reaction, allergy or sensitivity to generic equivalent, if Y7ou had a failed trial with generic equivalent, or if transitioning to a generic equivalent could result in destabilization or unnecessary risk to You. Your provider will need to file an appeal directly with OptumRx. If the appeal is approved, You will only be responsible to pay the preferred brand Co-pay. To initiate the appeal, Your doctor should call OptumRx at (877) 629-3117, and request to speak with the Prior Authorization area.

FORMULARY CLINICAL EXCEPTIONS

If Your Physician prescribes a non-preferred or excluded medication due to negative clinical results, such as an allergic reaction, that You experienced when using a preferred or generic medication, You may be eligible for coverage through a clinical exception. Your provider will need to request a Prior Authorization from OptumRx. Your doctor should call OptumRx at (877) 629-3117, and request to speak with the Prior Authorization area. If the Prior Authorization is approved for a non-preferred drug, You will pay the preferred drug co-pay. If the Prior Authorization is approved for an excluded drug, You will pay the non-preferred drug co-pay.

PREVENTIVE ITEMS AND SERVICES

Certain Prescriptions intended to prevent Illness and disease, as well as contraceptives, are covered at 100%. This applies to generic and certain single-source brand drugs as well as some over-the-counter (OTC) drugs (Prescription required). The list of preventive drugs should be used as a guide, and is not a comprehensive list. This list is subject to change as Affordable Care Act (ACA) guidelines are updated or modified. You may contact OptumRx for more information and updates.

PRESCRIPTION COVERAGE UNDER JEFFERSON CITY PUBLIC SCHOOL DISTRICT

If You are covered under the JEFFERSON CITY PUBLIC SCHOOL DISTRICT, Your Prescription drug coverage is integrated with Your medical Plan coverage. This means that You pay the full cost of Your non-preventive Prescription drugs until You meet the JEFFERSON CITY PUBLIC SCHOOL DISTRICT Plan year deductible. If You use an OptumRx participating pharmacy, You will receive a discount.

There are certain Prescription IRS-designated drugs that treat chronic conditions. For these IRS-designated drugs, You always pay only the appropriate Co-pays or member pays the difference charges as they are not subject to the JEFFERSON CITY PUBLIC SCHOOL DISTRICT deductible. The Co-pays count toward the out-of-pocket maximum (OPM). The OPM is integrated with medical Plan coverage. The following list, which is subject to change, provides the therapeutic classes of Prescription drugs considered preventive under federal guidelines:

- Anticoagulants;
- Antihypertensive agents (high blood pressure);
- Asthma/COPD;
- Cholesterol lowering agents;
- Diabetes;
- Heart disease;
- Hepatitis C;
- Immunosuppressant agents;

- Mental health and substance abuse agents;
- Prenatal vitamins;
- Thyroid disease; and
- Osteoporosis.

SPECIALTY MEDICATIONS

Specialty medications are not covered at a retail pharmacy and may be purchased only through OptumRx Specialty Pharmacy, Briova. Contact Briova at (855) 427-4682 to access these drugs.

OUT-OF-POCKET MAXIMUM (OPM)

If You are enrolled under the JEFFERSON CITY PUBLIC SCHOOL DISTRICT, Your OPM is integrated with Your medical Plan coverage. Therefore, Your OPM will combine Your eligible Prescription Plan expenses plus Your eligible medical Plan expenses. Once You have reached Your Plan year OPM, Your eligible medical and Prescription Plan expenses will be covered at 100% through the end of the Plan year.

Your Co-pays will track towards the OPM. However, penalties will not apply towards the OPM, such as the Member Pays the Difference programs. Therefore, if You meet Your OPM, You will still be charged the cost difference for the Member Pays the Difference program.

OPTUMRX PROGRAMS

JEFFERSON CITY PUBLIC SCHOOL DISTRICT participates in prior authorization, step therapy, quantity duration, and compound medication programs. The conditions or drug categories that may require prior authorization, step therapy and/or quantity duration includes, but are not limited to the following:

- Acne;
- Allergy and asthma;
- Anti-influenza agents;
- CNS stimulants/Strattera/amphetamines;
- Depression therapy;
- Erectile dysfunction therapy;
- Multiple Sclerosis therapy;
- Narcolepsy;
- Proton pump inhibitors;
- Pulmonary arterial hypertension therapy;
- RSV agents (respiratory syncytial virus;)
- Rheumatoid arthritis.

To determine if a drug requires prior authorization, step therapy, and quantity during review, You may contact OptumRx at (877) 629-3117.

An Optum Rx pharmacist may need to speak with the prescribing Physician to ensure that the patient meets the criteria for the Prescription prescribed. In addition, the quantity of some Prescription medications dispensed may be limited based on FDA regulations in order to ensure patient safety. If Your Physician deems it necessary for Your care and treatment, the Physician may appeal these limits directly with OptumRx. You or Your provider may check with OptumRx to verify covered Prescription drugs, any quantity and/or age limits, prior authorization or other requirements of the Plan.

OTHER IMPORTANT INFORMATION

JEFFERSON CITY PUBLIC SCHOOL DISTRICT reserves the rights to amend, suspend, or terminate its Prescription drug coverage in whole or in part, at any time and for any reason. JEFFERSON CITY PUBLIC SCHOOL DISTRICT has full authority and discretion to construe, interpret and administer its Prescription drug coverage. The Prescription drug coverage is unfunded, and no Employee or Dependent shall have any right to, or interest in, any assets of JEFFERSON CITY PUBLIC SCHOOL DISTRICT which may be applied by JEFFERSON CITY PUBLIC SCHOOL DISTRICT to the payment of benefits. Neither the establishment of the Prescription drug coverage, nor the provision of benefits to any person, shall be construed as giving an Employee the right to be retained in the service of JEFFERSON CITY PUBLIC SCHOOL DISTRICT.

CLAIMS PROCEDURE

You must use and exhaust the administrative claims and appeals procedure set forth below before bringing a suit in either state or federal court. Similarly, failure to follow the prescribed procedures in a timely manner will also cause You to lose Your right to sue regarding an Adverse Benefit Determination.

A pre-service claim is a request for coverage of a medication when Your coverage requires You to obtain approval before a benefit will be payable. For example, a request for prior authorization is considered a pre-service claim. For these types of claims (unless urgent as described below) You will be notified of the decision not later than 15 days after receipt of a pre-service claim that is not an urgent care claim, provided You have submitted sufficient information to decide Your claim. A post-service claim is a request for coverage or reimbursement when You have already received the medication. For post-service claims, You will be notified of the decision no later than 30 days after receipt of the post-service claim, as long as all needed information was provided with the claim.

If sufficient information to complete the review has not been provided, You will be notified that the claim is missing information within 15 days from receipt of Your pre-service claim and 30 days from receipt of Your post-service claim. You will have 45 days to provide the information. Once all of the needed information is received within the 45-day time-frame, You will be notified of the decision not later than 15 days after the later of receipt of the information or the end of that additional time period. If You don't provide the needed information within the 45-day period, Your claim is considered "deemed" denied and You have the right to appeal as described below.

If Your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes and any additional information needed to perfect Your claim. You have the right to a full and fair impartial review of Your claim. You have the right to review Your file and the right to receive, upon request and at no charge, the information used to review Your claim. If You do not speak English well and require assistance in Your native language to understand the letter or Your claims and appeals rights, please call (800)-626-0072. In addition, You may also have the right to request a written translation of Your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If You are not satisfied with the decision on Your claim (or Your claim is deemed denied), You have the right to appeal as described below.

URGENT CLAIMS (EXPEDITED REVIEWS)

An urgent care claim is defined as a request for treatment when, in the opinion of Your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize Your life or health or Your ability to regain maximum function or would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of Your claim. 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 provided there is sufficient information to decide the claim.

If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, You will be notified within 24 hours after receipt of Your claim that information is necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 48 hours of receipt of the information. If You don't provide the needed information within the 48-hour period, Your claim is considered "deemed" denied and You have the right to appeal as described below.

If Your claim is denied, in whole or in part, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes and any additional information needed to perfect Your claim. You have the right to a full and fair impartial review of Your claim. You have the right to review Your file and the right to receive, upon request and at no charge, the information used to review Your claim. If You do not speak English well and require assistance in Your native language to understand the letter or Your claims and appeals rights, please call (800)626-0072. In addition, You may also have the right to request a written translation of Your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If You are not satisfied with the decision on Your claim (or Your claim is deemed denied), You have the right to appeal as described below.

NON-URGENT APPEAL

If You are not satisfied with the decision regarding Your benefit coverage or You receive an Adverse Benefit Determination following a request for coverage of a Prescription benefit claim (including a claim considered "deemed" denied because missing information was not timely submitted), You have the right to appeal the Adverse Benefit Determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by You or Your authorized representative (such as Your Physician). To initiate an appeal for coverage, provide in writing:

Your name;
Member ID;
Phone number;
The Prescription drug for which benefit coverage has been denied; and
Any additional information that may be relevant to Your appeal.

This information should be mailed to OptumRx, c/o Appeals Coordinator, CA106-0286, 3515 Harbor Blvd, Costa Mesa, CA 92626 or fax to (866)511-2202. A decision regarding Your appeal will be sent to You within 15 days of receipt of Your written request for pre-service claims or 30 days of receipt of Your written request for post-service claims. If Your appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, the provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes and any additional information needed to perfect Your claim. You have the right to a full and fair impartial review of Your claim. You have the right to review Your file and the right to receive, upon request and at no charge, the information used to review Your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to You if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of Your claim).

If You do not speak English well and require assistance in Your native language to understand the letter or Your claims and appeals rights, please call (800) 626-0072. In addition, You may also have the right to request a written translation of Your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog).

If You are not satisfied with the coverage decision made on Your appeal, You may request in writing, within 90 days of the receipt of notice of the decision, a second level appeal. A second level appeal may be initiated by You or Your authorized representative (such as Your Physician). To initiate a second level appeal, provide in writing:

Your name;
Member ID;
Phone number;
The Prescription drug for which benefit coverage has been denied; and
Any additional information that may be relevant to Your appeal.

This information should be mailed to OptumRx, c/o Appeals Coordinator, CA106-0286, 3515 Harbor Blvd, Costa Mesa, CA 92626 or fax to (866) 511-2202. A decision regarding Your request will be sent to You in writing within 15 days of receipt of Your written request for pre-service claims or 30 days of receipt of Your written request for post-service claims. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered in relation to Your appeal, the provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes. You have the right to a full and fair impartial review of Your claim. You have the right to review Your file, the right to receive, upon request and at no charge, the information used to review Your second level appeal, and present evidence and testimony as part of Your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to You if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of Your claim). If You do not speak English well and require assistance in Your native language to understand the letter or Your claims and appeals rights, please call (800) 626-0072. In addition, You may also have the right to request a written translation of Your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If new information is received and considered or relied upon in the review of Your second level appeal, such information will be provided to You together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on Your second level appeal is final and binding.

If Your second level appeal is denied and You are not satisfied with the decision of the second level appeal (i.e., Your “final Adverse Benefit Determination”) or Your initial benefit denial notice or any appeal denial notice (i.e., any “Adverse Benefit Determination notice” or “final Adverse Benefit Determination”) does not contain all of the information required under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), You have the right to bring a civil action under ERISA section 502(a).
In addition, for cases involving medical judgment or rescission, if Your second level appeal is denied and You are not satisfied with the decision of the second level appeal (i.e., Your “final Adverse Benefit Determination”) or Your initial benefit denial notice or any appeal denial notice (i.e., any “Adverse Benefit Determination notice” or “final Adverse Benefit Determination”) does not contain all of the information required under ERISA, You have the right to an independent review by an external review organization. Details about the process to appeal Your claim and initiate an external review will be described in any notice of an Adverse Benefit Determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the Prescription drug coverage (e.g., Prescription drug coverage only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

URGENT APPEAL (EXPEDITED REVIEW)

You have the right to request an urgent appeal of an Adverse Benefit Determination (including a claim considered denied because missing information was not timely submitted) if Your situation is urgent. An urgent situation is one where in the opinion of Your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize Your life or health or Your ability to regain maximum function or would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of Your claim. To initiate an urgent claim or appeal request, You or Your Physician (or other authorized representative) must call (800) 626-0072 or fax the request to (866) 511-2202. Claims and appeals submitted by mail will not be considered for urgent processing unless and until You call or fax and request that Your claim or appeal be considered for urgent processing. 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. If the appeal is denied, the denial notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered in relation to Your appeal, the provisions on which the decision is based, a description of applicable external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist You with the claims and appeals processes. You have the right to a full and fair impartial review of Your claim. You have the right to review Your file, the right to receive, upon request and at no charge, the information used to review Your appeal, and present evidence and testimony as part of Your appeal. You also have the right to request the diagnosis code and treatment code and their corresponding meanings which will be provided to You if available (i.e., if the information was submitted, relied upon, considered or generated in connection with the determination of Your claim). If You do not speak English well and require assistance in Your native language to understand the letter or Your claims and appeals rights, please call (800) 626-0072. In addition, You may also have the right to request a written translation of Your letter if 10 percent or more of the people in the county where notification is mailed do not speak English well and are fluent in the same non-English language (e.g., Spanish, Chinese, Navajo or Tagalog). If new information is received and considered or relied upon in the review of Your appeal, such information will be provided to You together with an opportunity to respond prior to issuance of any final adverse determination. The decision made on Your urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

If Your appeal is denied and You are not satisfied with the decision of the appeal (i.e., Your “final Adverse Benefit Determination”) or any appeal denial notice (i.e., “Adverse Benefit Determination notice” or “final Adverse Benefit Determination”) does not contain all of the information required under ERISA, You have the right to bring a civil action under ERISA section 502(a).

In addition, for cases involving medical judgment or rescission, if Your appeal is denied and You are not satisfied with the decision (i.e., Your “final Adverse Benefit Determination”) or Your initial benefit denial notice or any appeal denial notice (i.e., Your “Adverse Benefit Determination” or “final Adverse Benefit Determination”) does not contain all of the information required under ERISA, You have the right to an independent review by an external review organization.

In addition, in urgent situations where the appropriate timeframe for making a non-urgent care determination would seriously jeopardize Your life or health or Your ability to regain maximum function, You also have the right to immediately request an urgent (expedited) external review, rather than waiting until the internal appeal process, described above, has been exhausted, provided You file Your request for an internal appeal of the Adverse Benefit Determination at the same time You request the independent external review. If You are not satisfied or You do not agree with the determination of the external review organization, You have the right to bring a civil action under ERISA section 502(a).

Details about the process to appeal Your claim and initiate an external review will be described in any notice of an Adverse Benefit Determination and are also described below. The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the Prescription drug coverage (e.g., Prescription drug coverage only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim.

EXTERNAL REVIEW PROCEDURES

The right to an independent external review is only available for claims involving medical judgment or rescission. For example, claims based purely on the terms of the Prescription drug coverage (e.g., Prescription drug coverage only covers a quantity of 30 tablets with no exceptions), generally would not qualify as a medical judgment claim. You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of, filing a civil action with respect to Your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, You must exhaust the internal claim review process described above, unless Your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or Your appeal is urgent. In the case of an urgent appeal, You can submit Your appeal in accordance with the above process and also request an external independent review at the same time, or alternatively You can submit Your urgent appeal for the external independent review after You have completed the internal appeal process.

To file for an independent external review, Your external review request must be received within 4 months of the date of the Adverse Benefit Determination (if the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day). Your request should be mailed or faxed to: OptumRx, c/o Appeals Coordinator, CA106-0286, 3515 Harbor Blvd, Costa Mesa, CA 92626 or fax to (866) 511-2202.

Non-Urgent External Review

Once You have submitted Your external review request, Your claim will be reviewed within 5 business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and You will be notified within 1 business day of the decision.

If Your request is eligible to be forwarded to an IRO, Your request will randomly be assigned to an IRO and Your appeal information will be compiled and sent to the IRO within 5 business days. The IRO will notify You in writing that it has received the request for an external review and if the IRO has determined that Your claim involves medical judgment or rescission, the letter will describe Your right to submit additional information within 10 business days for consideration to the IRO. Any additional information You submit to the IRO will also be sent back to the claims administrator for reconsideration. The IRO will review Your claim within 45 calendar days and send You, the Prescription drug coverage sponsor, and OptumRx written notice of its decision. If You are not satisfied or You do not agree with the decision, You have the right to bring civil action under ERISA section 502(a). If the IRO has determined that Your claim does not involve medical judgment or rescission, the IRO will notify You in writing that Your claim is ineligible for a full external review and You have the right to bring civil action under ERISA section 502(a).

URGENT EXTERNAL REVIEW

Once You have submitted Your urgent external review request, Your claim will immediately be reviewed to determine if You are eligible for an urgent external review. An urgent situation is one where in the opinion of Your attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize Your life or health or Your ability to regain maximum function or would subject You to severe pain that cannot be adequately managed without the care or treatment that is the subject of Your claim.

If You are eligible for urgent processing, Your claim will immediately be reviewed to determine if Your request is eligible to be forwarded to an IRO, and You will be notified of the decision. If Your request is eligible to be forwarded to an IRO, Your request will randomly be assigned to an IRO and Your appeal information will be compiled and sent to the IRO. The IRO will review Your claim within 72 hours and send You, the Prescription drug coverage sponsor, and OptumRx written notice of its decision. If You are not satisfied or You do not agree with the decision, You have the right to bring civil action under ERISA section 502(a).

MENTAL HEALTH BENEFITS

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

COVERED BENEFITS

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

Residential Treatment means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. (Coverage does not include services provided in a community-based residential facility or group home.)

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

(Applies to Benefit Plan(s) 001, 002) Outpatient Therapy Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and
- Must be provided by one of the following:
  - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided.
  - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
  - A state licensed psychologist.
  - A state licensed or certified Social Worker practicing within the scope of his or her license or certification.
  - Licensed Professional Counselor.
  - If outside of the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

(Applies to Benefit Plan(s) 003, 004) Outpatient Therapy Services are covered subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and

- The services must be provided by a Qualified Provider. If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.

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

MENTAL HEALTH EXCLUSIONS

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

- Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a Covered Benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.

- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:

  - Personality disorders; or
  - Sexual/gender identity disorders; or
  - Behavior and impulse control disorders; or
  - "V" codes (including marriage counseling).

- Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

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

COVERED BENEFITS

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

Residential Treatment means a sub-acute facility-based program which is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance related disorders. (Coverage does not include services provided in a community-based residential facility or group home.)

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

(Applies to Benefit Plan(s) 001, 002) Outpatient Therapy Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and
- Must be provided by one of the following:
  - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided
  - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
  - A state licensed psychologist.
  - A certified addiction counselor.
  - A state licensed or certified social worker practicing within the scope of his or her license or certification.
  - If outside of the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located, or a therapist with a Ph.D., or master's degree that denotes a specialty in psychiatry. The attending Physician, psychiatrist, or a counselor must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance use disorder and chemical dependency disorders.

(Applies to Benefit Plan(s) 003, 004) Outpatient Therapy Services are covered subject to all of the following:

- The Covered Person must receive the services in person at a therapeutic medical facility; and

- The services must be provided by a Qualified Provider: If outside the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country in which the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally-recognized licensing body for treatment of substance use disorder and chemical dependency disorders.

ADDITIONAL PROVISIONS AND BENEFITS

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

SUBSTANCE USE DISORDER EXCLUSIONS

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

The Plan will not pay for:

- Treatment or care considered inappropriate or substandard as determined by the Plan.

- Inpatient charges for the period of time when full, active treatment meeting the Medical Necessity for the Covered Person's condition is not being provided.

CARE MANAGEMENT

Utilization Management

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

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact-gathering and independent medical review, if necessary.

Special Notes: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who have received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or after Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

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

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

DEFINITIONS

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

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the Medical Necessity, effectiveness and appropriateness of health care services and treatment plans. Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.

- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over $1,500 or any Durable Medical Equipment rentals over $500/month.
- Prosthetics over $1,000.
- **(Applies to Benefit Plan(s) 003,004)** Qualifying Clinical Trials.
- Inpatient stays in a Hospital or Birthing Center that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Outpatient cholecystectomy (laparascopic).
- Hysterectomy (under age 30).
- Nasal septoplasty/rhinoplasty.
- MRA, MRI, PET and CT Scans.
- Physical therapy, speech therapy, occupational therapy and home infusion.
- Bariatric surgery.
- Genetic testing.

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

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

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD.

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

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case to case management for review. Case management opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points including the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within 30 calendar days of the receipt of request within Care Management, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Case Management

Case Management services are designed to identify catastrophic and complex Illnesses, transplants and trauma cases. UMR Care Management's nurse case managers identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating Physician and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine/Nurse Chat

NurseLine is a health information line that is available 24 hours per day, 7 days per week, that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

Nurse Chat is an online source of health and wellness information that is available 24 hours per day, 7 days per week. Covered Persons have one-on-one secure, real-time access to registered nurses through the Health Center on umr.com. These nurses provide information on a variety of health and wellness topics. Note: Triage is not part of the Nurse Chat experience. If a Covered Person needs triage assistance, Nurse Chat refers the Covered Person to NurseLine.

Health And Wellness

The **Health And Wellness** program provided by UMR Care Management helps Covered Persons better understand the importance of taking care of their health today, so they may have a healthier future. When Covered Persons understand this and engage in healthier lifestyle choices, they are less likely to develop a chronic, costly and often debilitating condition in years to come. This program's focus is on changing behaviors in the following areas:

- Eating habits.
- Activity and exercise.
- Weight management.
- Stress.
- Tobacco use.
- Personal health management (preventive care).

Clinical Health Risk Assessment (CHRA). This program identifies and stratifies populations based on current medical conditions and future risk, and also assesses the Covered Person's readiness to change. Program participants are asked general questions relating to medical history and lifestyle habits such as physical activity, stress management, tobacco cessation, nutrition, and weight management. Participants are also asked about existing medical conditions, including arthritis, asthma, back pain, Chronic Obstructive Pulmonary Disease (COPD), diabetes, heart disease, heart failure, hypertension and depression – as a comorbidity to another chronic condition we manage. The CHRA includes questions to assess the impact of the condition on daily life and the ability to self-manage the condition. The CHRA Member Report encourages the member to share the report with their health care provider and discuss the risk areas.

Additional Care Management Provisions

Kidney Resource Services (KRS)

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

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

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

COORDINATION OF BENEFITS

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

(Applies to Benefit Plan(s) 001, 002) The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

(Applies to Benefit Plan(s) 003, 004) The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays or Participation amounts, if any, will be applied before benefits are paid on the balance.

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

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below).
- Medical benefits under homeowner’s insurance policies.
- Medicare or other governmental benefits, as permitted by law. See below. This does not include Medicaid.
- This Plan does not, however, coordinate benefits with individual health or dental plans.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

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

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
    - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

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

  - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

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

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary. This rule does not apply if the rule in paragraph 3 (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

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

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

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

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

MEDICARE

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

(Applies to Benefit Plan(s) 001, 002) The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

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

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

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

- This Plan generally pays first under the following circumstances:

  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.

  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.

  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.

- Medicare generally pays first under the following circumstances:

  - You are no longer actively employed by an employer; and

  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also have COBRA continuation coverage through the Plan; or

  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or

- You or Your covered spouse have retiree coverage plus Medicare coverage; or

- Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).

- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as the primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether the Covered Person is enrolled in Medicare.

TRICARE

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

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

RIGHT OF RECOVERY

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

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

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

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

The following persons and entities are considered third parties:

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

You agree as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL EXCLUSIONS

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

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

1. **Abortions:** Unless a Physician states in writing that:

   - The mother's life would be in danger if the fetus were to be carried to term, or
   - Abortion is medically indicated due to complications with the pregnancy.

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

3. **Acupuncture Treatment.**

4. **Alternative / Complementary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

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

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

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

8. **Auto Excess:** Illness or bodily Injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage.

9. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.

10. **Biofeedback Services**.

11. **Blood:** Blood donor expenses.

12. **Blood Pressure Cuffs / Monitors.**

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

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

15. **Claims** received later than 12 months from the date of service.

16. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a Covered Benefit.

17. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court

18. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.

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

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

21. **Dental Services:**

    - The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for x-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident.
    - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
    - Dental implants including preparation for implants.

22. **Developmental Delays:** Occupational, physical, and speech therapy services related to Developmental Delays, mental retardation or behavioral therapy that are not Medically Necessary and are not considered by the Plan to be medical treatment. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

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

24. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

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

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

27. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.

28. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment. **(Applies to Benefit Plan(s) 003, 004)** This does not include Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

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

30. **Family Planning:** Consultation for family planning.

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

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

33. **Hearing Services:**

    - Purchase or fitting of hearing aids unless covered elsewhere in this SPD.
    - Implantable hearing devices unless covered elsewhere in this SPD.

34. **Home Births** and associated costs.

35. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

36. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

37. **Infertility Treatment:**

    - Fertility tests.
    - Surgical reversal of a sterilized state which was a result of a previous surgery.
    - Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
    - Artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
    - Embryo transfer.
    - Freezing or storage of embryo, eggs, or semen.
    - Genetic testing.

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

38. **Lamaze Classes** or other child birth classes.

39. **Learning Disability:** Non-medical treatment, including but not limited to special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

40. **Liposuction** regardless of purpose.

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

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

43. **Massage Therapy.**

44. **Maternity Costs, Other Than Routine Prenatal Medical Care Expenses** for Covered Persons other than the Employee or spouse.

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

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

47. **Nocturnal Enuresis Alarm** (Bed wetting).

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

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

50. **Not Determined to Meet Medical Necessity:** Services, supplies, treatment, facilities or equipment which the Plan determines do not meet the guidelines for Medical Necessity. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.

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

52. **Nutrition Counseling** unless covered elsewhere in this SPD.

53. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Medical Benefits.

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

55. **Panniculectomy / Abdominoplasty** unless determined by the Plan to be Medically Necessary.

56. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

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

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

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

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

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

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

63. **Self-Inflicted** unless due to a medical condition (physical or mental) or domestic violence.

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

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

66. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.

67. **Sex Therapy.**

68. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.

69. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.

70. **Standby Surgeon Charges.**

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

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

73. **Telemedicine - Telephone or Internet Consultations.**

74. **Temporomandibular Joint Disorder (TMJ) Services Surgical treatment.** This does not cover orthodontic services.

75. **Third Party Liabilities:** Any Covered Expenses to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. “Amounts received from others” specifically include, without limitation, liability insurance, worker’s compensation, uninsured motorists, underinsured motorists, “no-fault” and motor vehicle medical payments, and homeowner’s insurance.

76. **Tobacco Addiction (Applies to Benefit Plan(s) 001, 002):** Services, treatment or supplies related to addiction to or dependency on nicotine.

77. **Tobacco Addiction (Applies to Benefit Plan(s) 003, 004):** Diagnoses, services, treatment or supplies related to addiction to or dependency on nicotine.

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

79. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

80. **Vision Care** unless covered elsewhere in this SPD.

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

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

83. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency, or for care related to pregnancy that is expected to result in childbirth.

84. **Weight Control (Applies to Benefit Plan(s) 001, 002):** Treatment, services or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness. This does not include specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

85. **Weight Control (Applies to Benefit Plan(s) 003, 004):** Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This does not include specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

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

87. **Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.

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

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

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

Pre-Determination

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

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as <u>required</u> by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan ***before*** obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization (See Pre-Determination above). Giving prior authorization does not guarantee that the Plan will ultimately pay the claim.

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

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

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

PERSONAL REPRESENTATIVE

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

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

PROCEDURES FOR SUBMITTING CLAIMS

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

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

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

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

For Prescription benefits, a claim is considered filed when a Covered Person has submitted the claim for benefits under the Pharmacy benefit terms outlined in this SPD. The address for submitting Prescription claims is on the back of the identification card. If the Pharmacy refuses to fill the Covered Person's Prescription at the Pharmacy counter, the Covered Person should contact the number on the back of the Pharmacy drug benefit identification card for further instructions on how to proceed.

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. Where Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the timely filing period will not be allowed.

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

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

HOW HEALTH BENEFITS ARE CALCULATED

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

Claims for covered benefits are paid according to an established fee schedule, a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

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

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

Usual And Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 90th percentile, see surgery and assistant surgeon under the Covered Medical Benefits for exceptions related to multiple procedures. As it relates to charges made by a network provider, the term Usual and Customary means the Negotiated Rate as contractually agreed to by the provider and network (see above). A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

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

TIMELINES FOR INITIAL BENEFIT DETERMINATION

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

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.

- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- Emergency and/or Urgent Care Claim: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan. **(Applies to Benefit Plan(s) 003, 004).**

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

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a Covered Benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

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

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

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

- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on not meeting Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

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

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

- Covered Persons must file the appeal within 180 days of the date they received the EOB form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

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

- Covered Persons who are not satisfied with the decision following the first appeal have the right to appeal the denial a second time.
- Covered Persons or their Personal Representative must submit a written request for a second review within 60 calendar days following the date received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal seven days following the date the Plan sends the determination letter.

- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

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

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

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

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

Send second level Post-Service Claim Medical appeals to:
JEFFERSON CITY PUBLIC SCHOOL DISTRICT
315 E DUNKLIN ST
JEFFERSON CITY MO 65101

Send Pharmacy appeals to:
OPTUMRX - DIRECT
3500 BLUE LAKE DR STE 200
BIRMINGHAM AL 35243

Send second level Pharmacy appeals to:
JEFFERSON CITY PUBLIC SCHOOL DISTRICT
315 E DUNKLIN ST
JEFFERSON CITY MO 65101

TIME PERIODS FOR MAKING DECISION ON APPEALS

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

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

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

RIGHT TO EXTERNAL REVIEW

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

- Clinical reasons;
- The exclusions for Experimental or Investigational Services or Unproven Services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits); or
- Other requirements of applicable law.

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

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

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

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

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

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

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

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

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

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

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

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

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

PHYSICAL EXAMINATION AND AUTOPSY

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

RIGHT TO REQUEST OVERPAYMENTS

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

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

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

FRAUD

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

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

Covered Persons must:

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

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

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

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

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

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

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

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

The order must clearly identify all of the following:

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

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

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

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

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

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

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

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

CFO and Administrative Assistant to CFO

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means Your employer.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, in the alternative, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person received the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Customer should reflect the provisions of the Trust Agreement regarding distribution of assets upon termination of the Plan funded under the VEBA Trust.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: Bathing, dressing, toileting and associated personal hygiene; transferring (which is to move in and out of a bed, chair, wheelchair, tub or shower); mobility, eating (which is getting nourishment into the body by any means other than intravenous), and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or for treating condition of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

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

Alternate Facility means 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 services; or
- Rehabilitative, laboratory, diagnostic or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well being of You or Your Dependent.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency including the following: ambulance, anesthesiology, assistant surgeon, pathology and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a step Child; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's permanent or temporary Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, Children, step Children and grandchildren.

Co-pay is the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses means any expense, or portion thereof, which is Incurred as a result of receiving a Covered Benefit under this Plan.

Covered Person means an Employee, Retiree or Dependent who is enrolled under this Plan.

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Delays are characterized by impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Delays may not always have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental Illness or other neurological symptoms or Illness.

Durable Medical Equipment means equipment which meets all of the following criteria:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose with respect to an Illness or Injury.
- Generally is not useful to a person in the absence of an Illness or Injury.
- Is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined in the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins.
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the Enrollment Date is the first day coverage begins.

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; Emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician which is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, services of a Physician, physical or occupational therapist, home health aide services, pharmacy services, and Durable Medical Equipment.

Hospital means:

- A facility that is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term "Illness" when used in connection with a newborn Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date the service or treatment is given, the supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with Section § 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at the Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: Basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation and mathematical reasoning. Specific learning disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling and level of intelligence.

Legal Guardianship/Guardian means the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, mental illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, disease or its symptoms; and

- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- 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 Illness, Injury, disease or symptoms.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

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

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

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on Your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Mental Health Disorder means a disorder that is a clinically significant psychological syndrome associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness or death.

Morbid Obesity means a Body Mass Index (BMI) that is greater than or equal to 40 kg/m2. If there are serious (life-threatening) medical condition(s) exacerbated by, or caused by obesity not controlled despite maximum medical therapy and patient compliance with medical treatment plan, a BMI greater than or equal to 35 kg/m2 is applied. Morbid Obesity for a Covered Person who is less than 19 years of age means a BMI that falls above the 95th percentile on the growth chart.

or

A Covered Person who weighs more than 100 pounds over standard weight for height, sex and age; or a Covered Person who weighs more than two times the standard weight for height, sex and age; or for a Covered Person who is less than 19 years of age where the Body Mass Index falls above the 95th percentile on the growth chart.

Multiple Surgical Procedures means when more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefits means any medical benefit that is not an Essential Health Benefit. Please refer to the Essential Health Benefits definition.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventative maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician (Applies to Benefit Plan(s) 001, 002) means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

Physician (Applies to Benefit Plan(s) 003, 004) means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: doctor of medicine (MD); doctor of medical dentistry including an oral surgeon (DMD); doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of chiropractic (DC), doctor of optometry (OPT). Subject to the limitations below, the term Physician shall also include the following practitioner types: physician assistant (PA); nurse practitioner (NP); certified nurse midwife (CNM); or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means JEFFERSON CITY PUBLIC SCHOOL DISTRICT High Deductible Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug, that could be a medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

(Applies to Benefit Plan(s) 003, 004) For a High Deductible Health Plan, Preventive / Routine Care means care consistent with IRS Code §223(c)(2)(c) and as listed in the Schedule of Benefits, that can be paid by a high deductible health plan (HDHP) without the Covered Person satisfying the minimum Deductible under the Plan.

Primary Care Physician (Applies to Benefit Plan(s) 001, 002) means a family practitioner, general practitioner, non-specializing internist (i.e., those that work out of a family practice clinic), pediatrics, obstetrics/gynecology, or mental health/substance use disorder providers. Generally, these Physicians provide a broad range of services. For instance, nurse practitioners and family practitioners treat a wide variety of conditions for all family members; general practitioners give routine medical care; internist treat routine and complex conditions in adults; and pediatricians treat Children.

Primary Care Physician (Applies to Benefit Plan(s) 003, 004) means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or the treatment of mental health/substance use disorders. Generally, they provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified (Applies to Benefit Plan(s) 001, 002) means licensed, registered or certified by the state in which the provider practices.

Qualified (Applies to Benefit Plan(s) 003, 004) means licensed, registered and/or certified in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider (Applies to Benefit Plan(s) 003, 004) means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic when a physical impairment exists and the surgery restores or improves function.

Retired Employee (Retiree) means You are a Retired Employee if you terminate employment with the employer while covered by this Plan, and at the time you so terminate your employment to meet the requirements for retiree coverage under the Plan.

Retirement Date means the day immediately following your last date of employment as an Employee, if on such day you are a Retired Employee.

Specialist (Applies to Benefit Plan(s) 001, 002) means a provider who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Providers that are not considered a Specialist include, but are not limited to, nurse practitioners, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder providers.

Specialist (Applies to Benefit Plan(s) 003, 004) means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians that are not considered Specialists include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder providers.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- Provides drug services as needed for medical operations and procedures performed;
- Provides for the physical and emotional well being of the patients;
- Provides Emergency services;
- Has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

Temporomandibular Joint Disorder (TMJ) shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) is a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Disease – Clinical Modification manual (most recent revision) (ICD-CM) in the following categories:

    - Personality disorders; or
    - Sexual/gender identity disorders; or
    - Behavior and impulse control disorders; or
    - “V” codes.

Urgent Care is the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have an Injury or Illness that requires immediate care but is not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

You, Your means the Employee.