Lumen Retiree and Inactive Health Care Plan

UnitedHealthcare POS
(Choice Plus Network) and No-Network

Summary Plan Description (SPD)
For Qwest ERO '92 Retirees

Effective Jan. 1, 2022

You can go online to obtain an electronic copy or call the Lumen Health and Life Service Center at Businessolver, **833-925-0487** or **317-671-8494** (International callers), to request a paper copy of a Summary Plan Description (SPD).

Note: When enrolling during Annual Enrollment, Nov. 3 – Nov. 17, 2021, use lumen.com/bschealthandlife (if actively working) or lumen.com/bschealthbenefits. For the 2022 Plan year, use lumen.com/healthandlife (if actively working) or lumen.com/healthbenefits.

Issued Jan. 1, 2022

LUMEN®

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I. INTRODUCTION

LumenTechnologies* (hereinafter “Lumen” or “Company”) is pleased to provide you with this Summary Plan Description (“SPD”). This SPD presents an overview of your health care Benefits available under the UnitedHealthcare (“UHC”) Point of Service (“POS”) benefit option for Qwest ERO’92 Retirees (“ERO Retirees”).

The effective date of the ERO ‘92 Retiree Health Care Plan was January 1, 1992. The effective date of this revised Summary Plan Description is January 1, 2022. If you are a Covered Person in this benefit option of the Plan on or after January 1, 2022, this SPD supersedes and replaces, in its entirety, any other SPD describing medical plan Benefits for which you may be eligible. In the event of any discrepancy between this SPD and the official Plan Document, the Plan Document shall govern.

This SPD, together with other plan documents (such as the Plan Document, the Summary of Material Modifications (SMMs), the *General Information SPD* (“*General Information SPD*”) and materials you receive at Annual Enrollment (hereafter “Plan documents”) briefly describe your Benefits as well as rights and responsibilities, under the Lumen Retiree & Inactive Health Plan* (the “Health Plan”). These documents make up your official Summary Plan Description for the UHC POS Benefit option as required by the Employee Retirement Income Security Act of 1974, as amended and the regulations thereunder (“ERISA”). This ERO Retiree medical benefit option under the Plan is self-funded; however, certain other benefit plan options under the Health Plan are insured.

This SPD is only for Qwest Occupational ERO ‘92 (Enhanced Retirement Offer) Retirees who retired under this specific ERO offer in 1992.

Company’s Reserved Rights

This document summarizes the provisions of the Health Care Plan that is made available by Lumen for ERO Retirees. If there is any conflict between the terms of the Plan Document and this document, the terms of the Plan Document will govern. Lumen reserves the right to interpret and resolve any ambiguities in the Plan or any document relating to the Plan. The Plan Administrator has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan—including questions of eligibility, interpretations of the Plan provisions and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrator, shall be conclusive and binding on all persons.

The Company, as the Plan Administrator, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Lumen-sponsored plans, including the Qwest Health Care Plan. Lumen reserves the right to amend or terminate all of the Plans and the Benefits it sponsors and provides - with respect to all classes of Participants, retired or otherwise - and their beneficiaries, without prior notice to or consultation with any Participants and beneficiaries -subject to, applicable law, collective bargaining if applicable, the terms of the respective Plan documents, and with respect to the Health Plan, subject to the terms of the written agreement specific to Qwest Pre-1991 Retirees and Qwest ERO’92 Retirees.

Note: While the Plan has processes in place to prevent errors and mistakes, if a clerical error or mistake happens (however occurring) such error or mistake does not create a right to a Benefit or level of contribution rate under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Service Center to correct the error or omission. *There are deadlines to file claims and benefit related actions; please refer to the section titled* Time Deadline to File a Claim and the Time Deadline to File a Benefit-Related Lawsuit in *the General SPD for more information about the timing of these deadlines.*

The Required Forum for Legal Disputes

After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if a Participant wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

How To Use This Document

Most capitalized terms are defined in shaded boxes and throughout this SPD and in the *General Information SPD*. All uses of "we," "us," and "our" in this document, are references to the Plan Administrator, the Claims Administrator (UHC) or Lumen. References to "you" and "your" are references to people who are Covered Persons as the term is defined in the *General Information SPD*.

This SPD is provided to explain how the Plan works. It describes your Benefits and rights as well as your obligations under the Plan. It is important for you to understand that because this SPD is only a summary, it cannot cover all of the details of the Plan or how the rules will apply to every person in every situation. All of the specific rules governing the Plan are contained in the Plan Document. You and your beneficiaries may examine the Plan Document and other documents relating to the Plan during regular business hours or by appointment at a mutually convenient time in the office of the Plan Administrator. For additional information, refer to "Your Rights As A Plan Participant" section.

You are encouraged to keep this SPD and any attachments (SMM, Annual Enrollment materials, etc.) for future reference. Please note that your health care provider does not have a copy of the SPD and is not responsible for knowing or communicating your Benefits.

See the *General Information SPD* for more information as noted below.

II. GENERAL PLAN INFORMATION

The UHC benefit option is a Benefit offered under the Plan. Refer to the *General Information SPD* for general Plan information including, but not limited to, the following sections:

- When Coverage Ends
- Questions, Complaints, How to Appeal a Claim
- Circumstances that May Affect Your Plan Benefits
- The Plan's Right to Restitution
- Coordination of Benefits
- Plan Information (e.g. Plan Sponsor and EIN, administration, contact information, Plan Number, etc.)
- A statement of your ERISA Rights
- Notice of HIPAA Rights
- Your Rights to COBRA and Continuation Coverage
- Statement of Rights Under the Women's Health and Cancer Rights Act
- Statement of Rights Under the Newborns' and Mother's Health Protection Act
- Definitions
- Qualified Medical Child Support Order (QMCSO)

You can call the Lumen Health and Life Service Center at 833-925-0487 or 317-671-8494 (International callers) to request a paper copy of the General Information SPD or you can go online at lumen.com/healthbenefits to obtain an electronic copy.

Plan Determinations Are Not Health Care Advice

Please keep in mind that the sole purpose of the Plan (including its health, prescription, and dental benefit options) is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Employee, Retiree, or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean it is payable under the Plan. A determination by UHC or the Plan Administrator that a particular course of treatment is not eligible for payment or is not covered under the Plan does not mean that the recommended course of treatments, services or procedures should not be provided to the individual or that they should not be provided in the setting or facility proposed. ***Only you and your health care Provider can decide what is the right health care decision for you.*** *Decisions by UHC or the Plan Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice.*

Falsification Or Misrepresentation

You will be given advance written notice that coverage for you or your Dependent(s) will be terminated if you or your Dependent(s) are determined to falsify or intentionally omit information, submit false, altered, or duplicate billings for personal gain, allow another party not eligible for coverage to be covered under the Plan or obtain Plan Benefits, or allow improper use of your or your Dependent's coverage.

Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification of, or omission to, update information to the Plan. This misrepresentation/omission is a violation of the Plan document, Section 8.3 which allows the Plan Administrator to determine how to remedy this situation. For example, if you divorce, your former spouse is no longer eligible for Plan coverage and this must be timely reported to the Service Center within 45 days, regardless if you have an obligation to provide health insurance coverage to your ex-spouse through a Court Order.

- You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, the Plan Administrator may, without anyone's consent, terminate coverage, possibly retroactively, if permitted by law (called "rescission"), depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator (UHC) may refuse to honor any claim under the Plan or to refund premiums.
- While a court may order that health coverage must be maintained for an ex-spouse/domestic partner, that is not the responsibility of the Company or the Plan.
- You are also advised that by participating in the Plan you agree that suspected incidents of this nature may be turned over to the Plan Administrator and or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. All Covered Persons are periodically asked to submit proof of eligibility and to verify claims.

Note: *All Participants by their participation in the Plan authorize validation investigations of their eligibility for Benefits and are required to cooperate with requests to validate eligibility by the Plan and its delegates.*

For other loss of coverage events, refer to the General Information SPD as applicable.

III. ELIGIBILITY

See the *General Information SPD* for more information.

IV. ABOUT UNITEDHEALTHCARE MEDICAL COVERAGE

Medical coverage has been designed to help you and your family receive quality medical care when you need it most, while helping manage your medical expenses.

Despite all the precautions we take to guard our health and safety, virtually everyone needs professional medical care for an illness or injury at some time. When that happens, we want the best medical care possible for ourselves and our families.

The quality medical care we need is becoming increasingly expensive. That's why the Company provides you with protection through medical coverage. The UHC POS benefit option covers hospitalization, surgery, inpatient and outpatient care, diagnostics, mental health care and substance abuse treatment (administered by United Behavioral Health), home health care, and a variety of other medical services and supplies. This program promotes wellness by covering tests and procedures aimed at finding and solving potential problems.

The UHC POS benefit option also includes a number of medical cost and care management features such as provider Networks, designated Center of Excellence, and pre-notification programs. By aggressively working to contain medical care costs while also maintaining quality service, the Company helps keep high-quality medical care available for you and your Dependents.

V. CUSTOMER SERVICE CONTACT INFORMATION

Questions	The Claims Administrator's customer service staff is available to answer your questions about your coverage. Monday through Friday: 8:00 AM – 8:00 PM Hours are subject to change without prior notice.
Customer Service Telephone Number	800-842-1219 TDD 888-255-7485
UnitedHealthcare Web site	You are encouraged to visit myuhc.com to take advantage of several self-service features including: viewing your claim status, finding In-Network Physicians in your area, and ordering your prescription refills.
Care CoordinationSM	Prior notification is required before you receive certain Covered Health Services. Contact Care CoordinationSM at the number shown on your UHC ID card before receiving these services. Refer to Notification Requirements later in this SPD for additional information.
Mental Health/Substance Abuse	To arrange mental health/substance abuse pre-notification or to contact a care manager (available seven days a week, 24 hours a day), contact United Behavioral Health at 800-961-9378 (TDD line 800-842-9489).

Claims Administrator's Mailing Address	**Medical Claims:** To file medical claims, mail the claim form to: UnitedHealthcare Insurance Company Attention: Claims P. O. Box 30994 Salt Lake City, UT 84130 **Requests for Review of Denied Claims and Notice of Complaints:** **Medical Appeals/Complaints:** To file a medical appeal, mail the appeal to: UnitedHealthcare Appeals P.O. Box 30994 Salt Lake City, UT 84130 **Mental Health/Substance Abuse Appeals/Complaints:** For Covered Persons who file a formal written complaint, their advocate will be the appeals coordinator in Member Relations who will thoroughly investigate the matter and bring it to resolution. Resolution on formal complaints is communicated in writing within 30 days. You may submit written complaints to: United Behavioral Health Attn: Member Relations Department 425 Market Street, 27th Floor San Francisco, CA 94105-2426 **Prescription Drug Appeals:** To file an appeal, mail the appeal to: UnitedHealthcare Appeals P. O. Box 30994 Salt Lake City, UT 84130 For more information on how to appeal a claim, refer to the General Information SPD under the Questions, Complaints, How to Appeal a Claim section.
Prescription Drug Program	For information regarding Prescription Drugs and mail order refills call 800-842-1219 Refer to the Prescription Drug Program section later in this SPD for more information.

ALL YOUR MEDICAL BENEFIT OPTIONS allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator (UHC) network and who is available to accept you or your family members.

VI. YOUR MEDICAL COVERAGE

UNITEDHEALTHCARE® GROUP MEDICARE ADVANTAGE (PPO) PLAN

The level and type of Benefits provided under the UHC Group Medicare Advantage PPO Plan will be as described in the UHC SPD/Evidence of Coverage. To request a copy of the SPD/Evidence of Coverage contact UnitedHealthcare at 877-886-7313.

Your Network Choices

Where you live and which medical care providers you choose will determine how you fit into the UHC managed care Network.

The UHC POS benefit option includes a managed care Network established by UnitedHealthcare. UnitedHealthcare has negotiated fee schedules and certain care review procedures with a number of medical care providers. You typically experience lower Out-of-Pocket expenses by using Network providers.

If you participate in the UHC POS benefit option, your Network status will be either In-Network or Out-of-Network, depending upon which medical providers you choose if you live in a Network location. If you do not live in a Network location, your status will be No-Network.

In-Network Benefits

Your eligibility to participate in the UnitedHealthcare Network depends upon where you live. Network directories based upon postal ZIP Codes are available from UnitedHealthcare Customer Service upon request, or at myuhc.com.

To receive In-Network Benefits, you must live in a Network location and use providers that participate in the UHC Network. Generally, In-Network Benefits will be paid only if your medical care is provided or arranged by an In-Network provider. Even if you receive care at a Network Hospital, it must be arranged through a Network provider in order for you to receive In-Network Benefits.

You do not need to designate a Primary Care Physician (PCP). You and your family may select any Network Physician from those listed in the UnitedHealthcare provider directory at the time services are needed. You may also change Network Physicians without notifying UnitedHealthcare. You do not need a referral from a Network Physician to visit a Network specialist. However, in all cases, your medical care must be provided by a Network Physician in order for you to receive In-Network Benefits. Therefore, throughout this SPD, any references to PCP's should also be interpreted as Network Physicians.

If you live in a Network location, but you have Dependent children who live outside the Network location contact the Lumen Health and Life Service Center to determine what other options are available. Call UnitedHealthcare Customer Service to determine if a Network of providers is available where your child is living.

Primary Care Physician (PCP)

A Primary Care Physician (PCP) is a physician who has contracted with UnitedHealthcare, and who is licensed to practice in family practice, general practice, internal medicine, or pediatrics.

When receiving In-Network care:

- You pay only the Copay amounts, where applicable, for covered services.
- You will generally not have to file claim forms.
- All necessary pre-notifications, except for mental health care and substance abuse treatments, as described below, will be handled by your PCP.
- Network providers are contracted to accept a negotiated fee as payment in full, except for any Copays and charges for non-covered services.
- You must contact United Behavioral Health for pre-notification of all mental health/substance abuse Benefits (see the Health and Substance Abuse Treatment section for pre-notification information).

No-Network Benefits

You are a No-Network participant if you live outside the Network service area as defined.

While you can receive care from any health care provider, you can control your costs by taking advantage of the UnitedHealthcare Preferred Provider Organization (PPO). PPO providers have negotiated fees, so you will not have to pay expenses above the Eligible Expenses limits after you have satisfied any Deductible and Coinsurance responsibilities. Call UnitedHealthcare Customer Service to request a PPO Directory for your area. (See the PPO section below for more details.)

Copay

This is the payment you make to a Network Provider at the time you receive In-Network services. Once the Copay is satisfied, there are no Deductibles, Coinsurance is 100%, and there are no claims to file. Copays are not credited toward Deductibles or Out-Of-Pocket Maximums for No-Network or Out-of-Network expenses. See the Copay Benefit Chart in this SPD.

When receiving No-Network medical care:

- Benefits are subject to No-Network Deductibles and Coinsurance.
- In most cases, you will not have to submit claim forms as long as you use PPO providers.
- You must contact UnitedHealthcare Care Coordination℠ when pre-notification is required in order to receive maximum Benefits as described below (Check with your PPO Physician. He or she will handle pre-notification in most cases).
- You must contact United Behavioral Health (UBH) for pre-notification for all mental health/substance abuse Benefits. (See the Mental Health Care and Substance Abuse Treatment section for pre-notification information.)
- In addition to any Deductibles and Coinsurance payments, you will be responsible for all covered expenses charged by non-PPO providers that exceed Eligible Expenses limits.

If you live outside the Network service area, you and your family have the option of traveling to a Network service area to receive your care. You must contact the Lumen Health and Life Service Center to make arrangements to access In-Network Benefits.

Eligible Expenses

The Eligible Expenses charge, as determined by UnitedHealthcare, will be the lowest of the following:

- The actual fee for service.
- The fee the provider most frequently charges.
- An average of the fee most providers in the same or similar geographic regions usually charge.

Managing Your No-Network Costs

If you are a No-Network participant, you can help manage your Out-of-Pocket expenses when not seeing a PPO provider by requesting predetermination of program coverage before undergoing significant procedures. Contact UnitedHealthcare Customer Service for more information.

You can also request information from UnitedHealthcare Customer Service concerning Eligible Expenses charge levels for a given procedure by giving the procedure code and provider's ZIP Code to UnitedHealthcare. This information is updated semi-annually.

UnitedHealthcare Preferred Provider Organization (PPO)

UnitedHealthcare has negotiated fees for covered services with providers in areas where there are no Networks available. If you are receiving No-Network medical care, you can go to PPO providers and avoid paying expenses that are above the Eligible Expenses limits. PPO Benefits are available only to retirees (and their dependents) who are under age 65. You can get a directory of PPO physicians by calling UnitedHealthcare Customer Service 800-842-1219. The TDD number is 800-638-3806 or by visiting the provider website at myuhc.com.

UnitedHealthcare will attempt to negotiate lower charges under the No-Network Plan with providers whose charges exceed Eligible Expense levels by more than $300. You will be advised of any such efforts and of the results. If, despite these efforts, you exceed $1,500 (per person) of annual Out-of-Pocket expenses caused specifically by charges above Eligible Expense levels, the charges above $1,500 will be paid 100% by your program. However, any remaining Deductibles and Out-of-Pocket Maximums will still apply. In order to be reimbursed, you must submit a claim showing proof of payment and, if appropriate, payments by other insurance companies under coordination of benefits. Contact UnitedHealthcare Customer Service for details.

Deductible

The Deductible is the amount you must pay toward certain covered expenses each year before your program begins paying.

Out-Of-Network Benefits

If you live within the Network, you can choose-at any time during your coverage-to seek medical care from covered providers outside the Network. Services rendered outside of the Network will be subject to separate Deductibles, Coinsurance, and Out-of-Pocket Maximums.

When receiving Out-of-Network care:

- Benefits are subject to Out-of-Network Deductibles and Coinsurance.
- Deductibles, Coinsurance, and Out-of-Pocket Maximums are generally more costly to you than with Copays for In-Network care.
- You must submit claim forms to UnitedHealthcare to receive consideration for payment.
- You must contact UnitedHealthcare Care Coordination℠ when pre-notification is required in order to receive maximum Benefits. (See below for pre-notification information.)
- In addition to any Deductibles or Coinsurance payments, you will be responsible for all covered expenses that exceed Eligible Expenses limits.
- You must contact United Behavioral Health for pre-notification of all mental health and substance abuse benefits (see the Mental Health Care and Substance Abuse Treatment section for pre-notification information).

VII. HOW THE UHC POS BENEFIT OPTION WORKS

The UHC POS benefit option pays a portion of your covered medical expenses, depending on the Network status of the care. Your share of the costs is determined by Copays for In-Network care and by Deductibles, Coinsurance, and Out-of-Pocket Maximums if you receive No-Network or Out-of-Network care.

The UHC POS benefit option shares covered expenses with you based on In-Network Copays and No-Network and Out-of-Network Deductibles, Coinsurance, and Out-of-Pocket Maximums. To participate, you must belong to one of the eligible groups identified above.

Coinsurance

Coinsurance is the percentage of covered expenses your program pays after you pay the appropriate Deductible.

In-Network Expenses

You will be responsible for services not covered by the program and for the following expenses when you receive covered services through the UnitedHealthcare Network.

Copay Benefits

In-Network Copays are required only for the following services (after you pay the Copay, the program pays 100% of the remaining cost for covered services):

Service	Copay	Copay (Members residing in MN, Wisconsin and ND)
Physician's office visits (including your PCP, specialists, obstetrician/gynecologist)	$10 per visit	$10
Chiropractic visits (maximum of up to 40 medically necessary visits per year)	$10 per visit	20% (60 visits per calendar year)
Maternity care (pre- and post-natal care)	$10 initial copay	$10 initial copay
Outpatient surgical facility	$50 per use	$0
Urgent/Emergency care (physician's office)	$10 per visit	$10/Urgent $40/Emergency
Hospital emergency room/urgent care facility	$50 per visit (waived if admitted as an inpatient)	$40/Emergency (waived if admitted as an inpatient)
Physical, speech, and occupational therapy	$10 per visit	20%
Inpatient hospital admissions (Semi-Private Room, ICU, cardiac care, isolation)	$100 per admission* ($300 per year maximum per person)	$0
Wellness	$10 per visit	100%

*This Copay does not apply to inpatient admissions for mental health and substance abuse treatment. (See the Mental Health and Substance Abuse Treatment section for separate Copay requirements and additional information).

Special provisions applying to the following services are detailed in sections below:

- Hearing loss/testing.
- Mental health.
- Prescription drugs.
- Substance abuse.

In-Network services provided at 100% with no Copays include:

- Acupuncture, when used for anesthesia and administered by a covered provider.
- Administration of anesthesia.
- Allergy injections.
- Ambulance service to nearest local Hospital.
- Biofeedback, if performed by a covered provider and only for specific diagnoses.
- Blood and blood derivatives.
- Cardiac rehabilitation.
- Chelation therapy, when a covered service (such as a lab test) is performed by a covered provider, but facilities charges are not covered.
- Chemotherapy.
- Dental services related to an accidental Injury to Sound Natural Teeth.
- Diagnostic X-ray and lab.
- *Durable Medical Equipment rental (UnitedHealthcare can approve purchases), including wheelchairs, crutches, hospital beds, splints, surgical stockings (limited to two pair per year), etc.
- Eyeglasses and hearing aids (initial glasses or aid only) needed as a result of illness, Injury, or covered surgery while you are covered under your program.
- Electroshock therapy.
- Hemodialysis.
- Home health care.
- Hospice care.
- In-hospital Physician's visits and consultations.
- In-hospital well baby exam.
- Immunotherapy, in cases where the U.S. Food and Drug Administration has approved a specific drug for a specific disease and is administered by a professional.
- Oral surgery for specific conditions.
- Orthoptics, if needed for treatment of illness or Injury, excluding learning disabilities or reading problems such as dyslexia. The PCP must provide a referral to a legally qualified Physician (including ophthalmologists) for Benefits to be considered In-Network.
- Orthosis-orthotic device for the feet, when required as a result of surgery, birth defects, or diseases such as polio or rickets.
- Pain control centers (freestanding), when a covered service (such as a lab test) is performed by a covered provider, but facilities charges are not covered.
- Pre-admission testing.
- *Prostheses (artificial limbs, eyes, etc.).
- Radiation therapy.

- Second surgical opinions (when required by UnitedHealthcare Care CoordinationSM).
- Skilled nursing services.
- Sleep centers (freestanding), when a covered service (such as a lab test) is performed by a covered provider, but facilities charges are not covered.
- Center of Excellence. Centers of Excellence
- Surgeon and assistant surgeon fees.
- Trans Electrical Neuro Stimulator (TENS) units for treatment of severe intractable pain.

*If more than one piece of equipment can meet your functional needs, the Plan will pay for the most cost effective piece of equipment.

Note: While these services require no Copays, you will be responsible for any Copays associated with the visit to receive the services (for example, if you go to your Physician's office for treatment).

Covered Providers

You can receive Benefits for care from a Physician, nurse midwife, dentist, podiatrist, optometrist, chiropractor, or perfusionist (someone licensed and/or certified to help a Physician in managing the equipment and techniques used during outside-the-body circulation or for inducing prescribed hypothermia). For this purpose, Physician is someone who is licensed to prescribe and administer all drugs or to perform all surgery, or an osteopath. Providers are considered covered only for services within the scope of their licenses. (For covered providers of mental health care and substance abuse treatment, see corresponding section).

No-Network And Out-Of-Network Expenses

You will be responsible for services not covered by the program and for the listed No-Network Deductibles, Coinsurance, and Out-of-Pocket Maximums if you live outside the Network service area listed in the directory or the ZIP Code listing, or for the listed Out-of-Network Deductibles, Coinsurance, and Out-of-Pocket Maximums if you live in a Network location but choose to receive care that is not arranged or given by your Primary Care Physician. You will also be responsible for the Copays required under the mail-service and retail prescription drug programs and the mental health care and substance abuse treatment programs. The Copays required under these programs cannot be applied to any Deductibles or Out-of-Pocket Maximums.

No-Network and Out-of-Network Deductibles accumulate independently. If you satisfy your No-Network Deductible, move, and then begin to receive Out-of-Network services, you will have to satisfy the entire Out-of-Network Deductible for those services before Out-of-Network Benefits begin.

Note: Using providers in the UnitedHealthcare PPO will help you avoid any No-Network expenses above Eligible Expenses charges because these providers are under contract and agree to certain fee schedules.

Deductibles

Your Annual Deductible for No-Network or Out-of-Network services is shown below:

Coverage Category	No-Network Annual Deductible	Out-of-Network Annual Deductible	MN/ND & Western Wisconsin
Employee Only	$150	$300	No Network $0 Out of Network $300

Coverage Category	No-Network Annual Deductible	Out-of-Network Annual Deductible	MN/ND & Western Wisconsin
Employee + 1* (two people)	$150 each	$300 each	No Network $0 Out of Network $300
Family* (three or more)	$450 (three or more people)	$900 (three or more people)	No Network $0 Out of Network $900

* No individual can contribute more than one Employee (one person) Deductible toward the Deductible for a Family or Employee + 1 claim.

No-Network Deductibles will not apply to:

- Administration of anesthesia.
- Chemotherapy.
- Diagnostic X-ray and lab.
- Electroshock therapy.
- Hearing loss/testing. *
- Hemodialysis.
- Home health care.
- Hospice care.
- In-hospital Physician's visits and consultations.
- Mental health care. *
- Pre-natal care and delivery.
- Prescription drugs. *
- Radiation therapy.

* Additional information is available-see corresponding sections.

Out-of-Network Deductibles will not apply to:

- Hearing loss/testing.
- Mental health care.
- Prescription drugs.
- Center of Excellence.
- Substance abuse treatment.
- Wellness.

Coinsurance. After you meet the appropriate No-Network or Out-of-Network Deductible, the program begins paying a percentage of your covered expenses-the Coinsurance. The percentage paid is based on the negotiated rates for PPO providers and on Eligible Expenses rates for other providers. How much the program pays for each expense depends on the type of medical care you receive and whether the care is No-Network or Out-of-Network, as follows:

- 100% Coinsurance is provided for the following No-Network services, but only 80% is provided for Out-of-Network services:
- Chemotherapy.
- Diagnostic X-ray and lab.
- Electroshock therapy.
- Emergency care, other than in a Physician's office.
- Hemodialysis.
- Home health care.
- Hospice care.
- Hospitalization, including Semi-private Room, ICU, cardiac care, and delivery room and nursery (up to a maximum of 120 days for No-Network; for information on Hospital stays beyond 120 days).
- Outpatient facility charges.
- Pre-admission testing.
- Pre-natal care and delivery.
- Preventive care.
- Radiation therapy.

- Second surgical opinions (covered at 100% for Out-of-Network when required by UnitedHealthcare Care CoordinationSM).
- Skilled nursing facility care.
- Surgery.
- Urgent care, other than in a Physician's office.

Services Always Provided With 100% Coinsurance

The following services are provided with 100% Coinsurance for No-Network and Out-of-Network care:

- Center of Excellence.
- Wellness.

Out-of-Network Services:

- 95% Coinsurance is provided for the following No-Network services, but only 80% for Out-of-Network services:
  - Urgent care at your Physician's office.
  - Emergency care at your Physician's office.
- 90% Coinsurance is provided for the following No-Network services, but only 80% for Out-of-Network services:
  - Anesthesia administration.
  - Consultation visits (generally one visit per specialty per admission).
  - Physician's in-hospital medical care visits.
  - Elective second surgical opinions (covered 100% if required by UnitedHealthcare Care Coordination[SM])
  - In-hospital well baby exam.
- 80% Coinsurance is paid for No-Network Other Covered Services and Out-of-Network services, including these medically necessary services and supplies:
  - Acupuncture, when used for anesthesia and administered by a covered provider.
  - Allergy injections.
  - Ambulance service to nearest local Hospital.
  - Biofeedback, if performed by a covered provider and only for specific diagnoses.
  - Blood and blood derivatives.
  - Cardiac rehabilitation.
  - Chelation therapy, when a covered service (such as a lab test) is performed by a covered provider, but facilities charges are not covered.
  - Chiropractic services are limited up to a maximum of 40 medically necessary visits per calendar year regardless of Network status.
  - Dental services, related to an accidental Injury to Sound Natural Teeth.
  - *Durable Medical Equipment rental (UnitedHealthcare can approve purchases), including wheelchairs, crutches, hospital beds, splints, surgical stockings (limited to two pair per year), etc.
  - Eyeglasses and hearing aids (initial glasses or aid only), needed as a result of illness, Injury, or covered surgery while you are covered under your program.
  - Immunotherapy, in cases where the U.S. Food and Drug Administration has approved a specific drug for a specific disease and is administered by a professional.
  - Hospitalization over 120 days.
  - Orthoptics, if needed for treatment of Illness or Injury, excluding learning disabilities or reading problems such as dyslexia.
  - Orthosis-orthotic devices for the feet, when required as a result of surgery, birth defects, or diseases such as polio

or rickets.

- Pain control centers (freestanding), when a covered service (such as a lab test) is performed by a covered provider, but facilities charges are not covered.
- Physical therapy when prescribed by a Physician and authorized by UnitedHealthcare.
- Physicians' fees for non-emergency and non-urgent office visits for treatment and/or diagnostic services.
- *Prostheses (artificial limbs, eyes, etc.).
- Skilled nursing services.
- Sleep centers (freestanding), when a covered service (such as a lab test) is performed by a covered provider, but facilities charges are not covered.
- Speech therapy to restore or rehabilitate any speech loss or impairment caused by an Injury or illness or otherwise authorized by UnitedHealthcare.

- Trans Electrical Neuro Stimulator (TENS) units for treatment of severe intractable pain.

*If more than one piece of equipment can meet your functional needs, the Plan will pay for the most cost effective piece of equipment.

Urgent Care

Urgent care is treatment given when an Illness or Injury that is not life threatening or likely to cause serious impairment requires prompt medical attention. Examples include persistent vomiting, high fever, a severe sore throat, a bad sprain, or a fracture.

Emergency Care

Emergency care is treatment required when an illness or Injury may result in death or serious impairment without immediate care. Examples include severe bleeding or burns, heart attack, unconsciousness, or serious breathing problems.

For No-Network services covered at 95% and 90%, the remaining expense is then submitted for coverage in this Other Covered Services category which covers 80%. You pay any remaining costs.

For example, consider a No-Network Physician in-hospital visit expense of $200. The 90% Coinsurance will pay $180, leaving $20. The Other Covered Services Coinsurance of 80% will pay $16, leaving you to pay $4, assuming your Deductible has already been met.

If your Coinsurance expenses reach the Out-of-Pocket Maximum, the UHC POS benefit option begins paying 100% of covered Eligible Expenses charges.

Out-Of-Pocket Maximum

The maximum you will pay annually for No-Network or Out-of-Network services is:

Coverage Category*	No-Network Annual Out-of-Pocket Maximum	Out-of-Network Annual Out-of-Pocket Maximum	MN/ND & Western Wisconsin
Employee (one person)	$1,000	$3,000	No-Network $1,000 Out-of-Network $3,000

Coverage Category*	No-Network Annual Out-of-Pocket Maximum	Out-of-Network Annual Out-of-Pocket Maximum	MN/ND & Western Wisconsin
Employee +1* (two people)	$1,000 each	$3,000 each	No-Network $1,000 Out-of-Network $3,000
Family* (three or more)	$3,000 (three or more people)	$6,000 (three or more people)	No-Network $3,000 Out-of-Network $6,000

* No individual can contribute more than one Employee (one person) Out-of-Pocket Maximum toward the Out-of-Pocket Maximum for a Family or Employee + 1 claim.

Once your expenses reach your No-Network or Out-of-Network Out-of-Pocket Maximum, excluding the Deductible, the program will pay 100% of any additional Eligible Expenses covered No-Network or Out-of-Network expenses for the remainder of the year.

Your No-Network and Out-of-Network Out-of-Pocket Maximums accumulate independently. If you satisfy your No-Network Out-of-Pocket Maximum, move, and then you begin to receive Out-of-Network services, you will have to satisfy the entire Out-of-Network Out-of-Pocket Maximum.

Out-Of-Pocket Maximum

Once your share of certain covered expenses-not counting any Deductibles-reaches the Out-of-Pocket Maximum, the program pays 100% of those Eligible Expenses covered expenses for the rest of the year. Expenses for mental health care/substance abuse treatment and prescription drugs cannot be applied to the Out-of-Pocket Maximums.

Coverage Rules For Retirees Married To Other Employees Or Retirees

If both you and your Spouse (including Domestic Partnerships) are covered under the Company benefit options, here is how the ERO UHC POS benefit option coverage applies:

- Each of you must choose coverage for yourselves, unless one of you has the option to waive medical coverage (Retirees can waive coverage). If one Spouse waives coverage, he or she can be covered as a Dependent by the other Spouse. Only one of you can cover Dependents common to both of you.
- If you and your Spouse both are covered by the ERO UHC POS benefit option (even if enrolled separately), any No-Network Deductibles and Out-of-Pocket Maximums will be combined to determine when the family No-Network Deductibles and Out-of-Pocket Maximums are met.
- If you and your Spouse both are covered by the ERO UHC POS benefit option (even if enrolled separately), any Out-of-Network Deductibles and Out-of-Pocket Maximums will be combined to determine when the family Out-of-Network Deductibles and Out-of-Pocket Maximums are met.
- If you or your Spouse are enrolled with coverage administered through an UHC benefit option each of you must satisfy the separate Deductibles, Out-of-Pocket Maximums and other rules of each of your medical benefit options.
- If your Spouse retired prior to January 1, 1991 (known as a Pre-1991 Retiree) and is covered under one of the Company Pre-1991 Retiree benefit options, you each must satisfy your own Deductible and Out-of-Pocket Maximum.

VIII. UNITEDHEALTHCARE CARE COORDINATION℠

Full Benefits will be payable for hospitalization, surgery, and other procedures if you take advantage of this important feature.

The UnitedHealthcare Care CoordinationSM program helps ensure that you and your Dependents receive

high-quality care while being protected against unneeded hospital stays, surgery, and other medical procedures.

Care CoordinationSM determines whether the services or supplies are covered health services. No Benefits are payable unless Care CoordinationSM determines the services and supplies are covered under the Plan.

The Care CoordinationSM program is designed to encourage an efficient system of care for you and your Dependents by identifying and addressing possible unmet covered health care needs. This may include admission counseling, inpatient care advocacy, and certain discharge planning and disease management activities.

Care CoordinationSM is triggered when UnitedHealthcare receives notification of an upcoming treatment or service. The notification process serves as a gateway to Care CoordinationSM activities and is an opportunity for you to let UnitedHealthcare know that you are planning to receive specific health care services. The services requiring notification include:

- Hospital admissions (if an Emergency admission to a Non-Network provider occurs, you should call within two business days).
- Skilled nursing facility admissions
- Hospice care
- Inpatient surgery
- Home health care services.
- Durable Medical Equipment (if the equipment costs more than $1,000).
- Prosthetic Devices (if the device costs more than $1,000).
- Reconstructive procedures.
- Maternity Services (if stay exceeds the 48/96 guidelines).
- Accidental dental services.
- Transplant services.

UnitedHealthcare may be contacted by calling the phone number listed on your ID card.

You can expect to receive phone calls from the UnitedHealthcare when certain treatments are involved.

The ultimate decisions on medical care must be made by the covered person and his or her physician. Care CoordinationSM only determines if the service or supply is a covered according to the program Benefits and provisions.

Approval by Care CoordinationSM does not guarantee that Benefits are payable under the program. Benefits are based on:

- The covered health services actually performed or given.
- The covered person's eligibility under the program on the date the covered health services are performed or given.

For Out-of-Network care, contact UnitedHealthcare Care Coordination℠ at 800-638-7388 Monday-Friday from 6 AM until 6 PM (Mountain Time).

Definition of Experimental Or Investigational

Experimental or investigational refers to medical, surgical, diagnostic or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by UnitedHealthcare (at the time it makes a determination regarding coverage in a particular case) to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service, the United States Pharmacopeia Dispensing Information, or the

American Medical Association Drug Evaluations as appropriate for the proposed use.

- Subject to review and approval by any Institutional Review Board for the proposed use.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

If you have a life-threatening Sickness or condition (one which is likely to cause death within one year of the request for treatment) UnitedHealthcare may, in its discretion, determine that an experimental or investigational service meets the definition of a covered health service for that Sickness or condition. For this to take place, UnitedHealthcare must determine that the procedure or treatment is promising, but unproven, and the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Notification Responsibility

The responsibility for providing the appropriate notification to UnitedHealthcare depends on whether you are receiving In-Network services, Out-of-Network services, or No-Network services.

In-Network Services. You don't need to get pre-notification, so long as your medical services are arranged through your PCP or you access a Network provider if you live in Utah. It is the responsibility of your PCP or referred In-Network specialist to pre-authorize care. You have 48 hours after an Emergency Hospital admission to contact your PCP. Otherwise, Benefits will be paid on an Out-of-Network basis or your claims may be denied if determined as not medically necessary.

For No-Network care, contact UnitedHealthcare Care Coordination℠ at 800-638-7388.

Chiropractic services. To receive In-Network Benefits for Chiropractic Care, you must have selected a PCP through UnitedHealthcare or accessed In-Network care.

No-Network or Out-of-Network services. It is your responsibility to contact UnitedHealthcare Care Coordination℠ in advance of planned hospital admissions or within 48 hours in the case of Emergency situations. If the 48-hour period ends during non-business hours, you should call as soon as possible during the next business day. Also, you must get pre-notification for:

- Home health care.
- Hospice care.
- Hospital admissions.
- Magnetic Resonance Imaging (MRI scans).
- Organ transplants.
- Positron Emission Tomography (PET scans).
- Skilled nursing facility care.
- Surgical procedures (inpatient and outpatient).

To obtain pre-notification, you may be required to get a second opinion (for example, before surgery). When possible, submit your pre-notification request well in advance so that you will have time for a second opinion.

Case Evaluation

Upon notification, UnitedHealthcare Care Coordination℠ will collect information concerning the condition of the patient, the proposed treatment plan, the length of any proposed Hospital stay, the name of the Physician, and any other medical information that would be needed for the review.

If the care is a covered health service. Care Coordination℠ will provide confirmation by phone to whoever initiated the notification.

In case of a denial. You and your Physician will receive a letter of explanation.

If you are hospitalized. UnitedHealthcare Care Coordination℠ will continue to review your case to ensure

that your hospital care is appropriate and consistent with your Physician's orders. UnitedHealthcare Care Coordination℠ will also work with your Physician to plan your discharge from the Hospital.

Mental Health and Substance Abuse Treatment Pre-notification

All care must be pre-authorized regardless of your UnitedHealthcare Network status (see "MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT PROGRAM" on page 25).

Case Management

Appropriate candidates for case management are identified through the pre-notification and concurrent review process, which allows an early evaluation to be done if you have a diagnosis that has the potential for complicated or high-cost care. Your case will be followed until an alternate Benefits program or management Benefits program is appropriate and that plan will be communicated to you and your Physician. Your case will be reviewed periodically to make sure that case management continues to be appropriate.

UnitedHealthcare Care Coordination℠ will provide this individual attention to ensure that you or your Dependents receive appropriate and cost-effective care in the event of cases such as:

- Selected blood disorders.
- Traumatic brain injury.
- Spinal cord injury.
- Crohn's Disease.
- Certain neonatal conditions.
- Multiple Sclerosis.
- Neurological conditions.
- AIDS.
- Severe rheumatoid arthritis.
- Severe burns.
- Certain respiratory conditions.
- Multiple fractures.
- Organ transplants.

Nurse reviewers at the Care Coordination℠ center may also identify other illnesses or injuries that may benefit from case management intervention.

Penalty

Failure to obtain the necessary pre-notification for No-Network and Out-of-Network services will result in an additional $250 Deductible being applied per occurrence. This Deductible cannot be used to satisfy Out-of-Pocket Maximums.

If you are In-Network and do not use your PCP, all services will be paid as Out-of-Network Benefits. You will also be subject to the additional $250 Deductible for services that require pre-notification.

Also, if you do not get the necessary pre-notification, you run a greater risk of having some or all of your medical expenses deemed medically unnecessary and not covered by the program.

If Services Are Denied

If your request for pre-notification is denied, you or your Physician will receive the denial in writing. It will include the reason, reference to the pertinent program provisions, and information on what material would be needed to make your claim acceptable. You can appeal the denial by making a written request to

UnitedHealthcare Care Coordination℠ at the address provided on the denial letter.

Your appeal review will be handled by a Physician chosen by UnitedHealthcare who is not involved in your care or in the decision to deny your original request. Additional reviewers in the appropriate specialty area may also be consulted.

You will be responsible for any costs associated with making your medical records available for review. If you met the program requirements when applying for pre-notification, responses will be issued (after your written request and all the pertinent data have been received) according to the following schedule:

See the General Information SPD for more details on how to file an appeal.

IX. HOSPITALIZATION AND ALTERNATIVES

The UHC POS benefit option pays Benefits if you or a covered Dependent needs care in a Hospital or an alternative covered facility.

Your Benefits for hospitalization and for alternatives to a Hospital stay will be paid according to the Copays, Deductibles, Coinsurance, and Out-of-Pocket Maximums governing the Network status of the services. Remember, you must pre-authorize any Out-of-Network and No-Network hospitalization.

See “HOW THE UHC POS BENEFIT OPTION WORKS” on page 8 for more information on how the costs are shared.

Covered Hospital Charges

Your Semi-Private Room and board charges, including all regular daily services and stays in intensive care units, cardiac care units, or isolation rooms, are covered.

Other standard hospital services and supplies, such as X-rays, medicines, lab tests, radiation therapy, oxygen therapy, physical therapy, and the use of operating and recovery rooms, are also covered. Coverage is provided according to the Network status of the services under your program.

If you are an In-Network participant. You will be responsible for your Copay and any additional cost if you choose a private room instead of a Semi-Private Room.

If you are an Out-of-Network or No-Network participant. Private room charges are covered at the Hospital’s standard rate for a Semi-Private Room. If the Hospital has only private rooms, the rate will be paid if it is consistent with average, prevalent Semi-Private Room rates in the area. If the Hospital has only private rooms and those rates are higher than the average, prevalent Semi-Private Room rates in the area, 90% of that private room charge will be covered according to the Network status of the stay. If you choose a private room, you are responsible for paying the difference between private room and Semi-Private Room costs.

Hospital

A Hospital is a state-licensed facility that primarily provides, on an inpatient basis, diagnostic and therapeutic facilities for both surgical and medical diagnosis, treatment, and care under the supervision of a staff of Physicians. Hospitals must continuously provide 24-hour-per-day services of a registered graduate nurse. It must not, other than incidentally, be a place of rest, a place for the aged, a nursing home, a place for drug addicts or alcoholics (unless specifically approved by a care manager), or a hotel.

Inpatient

To be considered an inpatient, you must be admitted to a covered facility for bed occupancy and be reasonably expected to stay there at least 24 hours for medically necessary reasons.

What If You Leave And Re-Enter The Hospital?

In-Network: If you leave and re-enter an In-Network hospital, you pay a new Copay no matter how much time passes between admissions until you meet your annual $300 maximum.

No-Network and Out-of-Network: Hospital stays for the same or related medical conditions must be separated by at least 90 consecutive days with no hospital confinement in order to be treated as separate stays.

Outpatient Facility Charges

Coverage for outpatient facility charges is provided according to the Network status of the services. Outpatient facilities include qualified ambulatory surgical facilities, hospital outpatient departments, or emergency rooms. For urgent care or Emergency care, outpatient facilities include hospital outpatient departments, emergency rooms, urgent care treatment centers, and physicians' offices.

Emergency And Urgent Care

For In-Network Benefits:

Your PCP must be contacted in advance of urgent care and within 48 hours following emergency care, even if the patient is temporarily outside the Network, or Benefits will be paid according to Out-of-Network schedules. You also face a greater risk of having some or all of your expenses classified as medically unnecessary and not covered if you do not contact your PCP. Non-emergency visits to an emergency room will be paid as Out-of-Network.

For No-Network or Out-of-Network Benefits:

UnitedHealthcare will review each case and make a determination based on the individual circumstances. Generally, if emergency treatment is received more than 72 hours after the onset of the condition, the claim will be treated as a non-emergency office visit.

Emergency Care. Emergency care is treatment required when an illness or Injury may result in death or serious impairment without immediate care. Examples include severe bleeding or burns, heart attack, unconsciousness, or serious breathing problems.

Urgent Care (In-Network only). Urgent care is treatment given when an illness or Injury that is not life threatening or likely to cause serious impairment requires prompt medical attention. Examples include persistent vomiting, high fever, a severe sore throat, a bad sprain, or a fracture.

Emergency Procedure. In the event of a life-threatening Illness or Injury, always call 911 or the designated

emergency number for your area to arrange for immediate transportation to the Hospital.

Excluded Hospital Charges

A number of general charges excluded from coverage are listed in the *What the Program Does Not Cover* section.

In addition, the following hospital charges are not covered:

- Hospitalization primarily for convalescent or rehabilitative care (except for certain rehabilitation which cannot be provided on an outpatient basis).
- Hospitalization for dental care, unless the care is required due to an accidental Injury or unless a Physician, oral surgeon, or dentist certifies that a hospital stay is necessary to safeguard your life or health.
- Friday, Saturday, and Sunday room and board charges for non-emergency admissions, unless surgery or treatment other than routine care is performed the day after the admission.

Alternatives to Hospitalization

Hospitalization alternatives include:

- Home health care.
- Hospice care.
- Skilled nursing facility care.

Coverage is provided according to the Copays, Deductibles, Coinsurance, and Out-of-Pocket Maximums of the type of Network services you receive. Any days spent receiving hospitalization alternative services do not count against the 120-day hospitalization limit that is part of No-Network coverage.

Pre-notification is required by UnitedHealthcare Care CoordinationSM before receiving care. In addition:

- Services must be in place of otherwise medically necessary hospitalization for a covered Illness or Injury, and generally be more cost-effective than hospitalization.
- The patient's Physician must establish and approve the treatment plan, and then review it at least every 30 days.
- The Physician must examine the patient at least once every 60 days.

Because a number of conditions may be imposed on these alternatives, pre-notification is a particularly important step that will help you avoid denied coverage or uncovered Out-of-Pocket expenses.

Hospitalization Alternatives

Home health care. Skilled nursing care and other therapeutic medical services provided by qualified health care personnel in a patient's home on an intermittent basis. Respite care is also available if authorized by UnitedHealthcare Care Coordination℠. Care is limited and cannot exceed seven (7) eight-hour days per each home health care period of 60 days. Respite care is care that is provided to temporarily relieve the patient's family from the daily demand of patient care.

Hospice. A program or facility that provides services to meet the physical, psychological, and social needs of terminally ill patients and their families.

Skilled nursing facility. A licensed institution providing 24-hour nursing services and treatment for patients convalescing from Illness or Injury.

X. SURGERY

The UHC POS benefit option pays Benefits if you or a covered Dependent undergoes inpatient or outpatient surgery.

Surgical Benefits

Your Benefits will be paid according to the Copays, Deductibles, Coinsurance, and Out-of-Pocket Maximums governing the Network status of the services under your program. Remember, you must get pre-notification for any Out-of-Network or No-Network hospitalization or any inpatient or outpatient surgery.

See “HOW THE UHC POS BENEFIT OPTION WORKS” on page 8 for more information on how the costs are shared.

Your surgery Benefits cover the Physician’s charges for surgical procedures, including endoscopic, obstetrical, initial sterilization, and permanent implants of internal prostheses. Customary pre- and post-operative care is also covered.

Note: Pre-notification is required for all surgery, whether inpatient or outpatient.

Oral Surgery

The diagnosis and surgical and adjunctive treatment of diseases, injuries, and defects of the mouth, the jaw, and associated structures.

Assistants During Surgery

Your program provides coverage for Physicians, a physician’s assistant, registered nurses, and non-MD surgical assistants who actively assist an operating surgeon during a covered procedure at a Hospital or covered ambulatory surgical facility. Coverage is also provided for the medically necessary services of a standby Physician who is present at the surgery.

The claims administrator will determine the medical necessity of the assistance and may require certification from the surgeon and reports from any assistants.

XI. MATERNITY BENEFITS

Physician and Hospital charges associated with pregnancy and birth are covered by the UHC POS benefit option.

Female employees and covered female Dependents are eligible for maternity Benefits. Coverage applies even if the pregnancy began before you or your Dependent became eligible. However, any expenses incurred before your program coverage begins or after your program coverage ends will not be paid.

Covered services include:

- Delivery charges.
- Cesarean sections.
- Ectopic pregnancies.
- Miscarriage or abortion.
- Obstetrical care (in or out of the Hospital).

Any Copays, Deductibles, Coinsurance, and Out-of-Pocket Maximums associated with your program apply to any covered services related to maternity.

See “HOW THE UHC POS BENEFIT OPTION WORKS” on page 8 for more information on how the costs are shared.

The following maternity services and procedures are covered:

- Hospitalization
  - Facility fees for stays at a Hospital or birthing center operating under the license of a Hospital.
  - Routine nursery care (during mother’s covered confinement).
  - PKU tests.
  - Ultrasound/sonograms (if medically necessary).
  - Newborn’s initial exam.
- Surgery
  - Delivery.
  - Circumcision.

If you are an In-Network participant. The initial physician visit relating to pregnancy requires a $10 Copay. Once pregnancy is established, one $10 Copay will be required for all of your pre-natal care.

If you are an Out-of-Network or No-Network participant. The initial physician visit relating to pregnancy has Coinsurance coverage of 80% after the Deductible is satisfied.

In-Network Obstetrical/Gynecological Services

Women can receive In-Network Benefits from a Network obstetrician/gynecologist for treatment within that specialty without referral from their PCP.

Newborn’s and Mothers’ Health Protection Act

Under federal law, group health plans and health insurance issuers offering group insurance coverage generally may not restrict Benefits for any length of childbirth-related hospital stay for the mother or the newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not require a provider to obtain authorization from the Plan or the insurance issuers for prescribing a length of stay that doesn’t exceed the above periods.

Newborn Treatment

During and after the mother’s covered maternity confinement an infant requiring definitive treatment of any Illness or Injury is covered” When Coverage Begins” section of the “General Information” SPD. That means a new Copay or Deductible must be satisfied. However, this coverage does not apply to infants of unmarried Class I dependent children after the mother’s maternity confinement, nor to infants of Class II dependents or sponsored children (unless such infants are separately covered under the program as Class I or II dependents).

Well Child Care

If you are an In-Network participant. You must use an In-Network pediatrician in order to receive In-Network Benefits.

If you are an Out-of-Network or No-Network participant. A schedule of physical exams and immunizations for

children is included in the Wellness section.

UnitedHealthcare's Healthy Pregnancy Program

Participants identified as being at high risk for premature labor and delivery have the option of participating in the UnitedHealthcare Healthy Pregnancy Program. This program combines education with care management to help prevent or delay premature delivery.

To enroll in the program, call the toll-free number on the back of your ID card.

XII. CENTER OF EXCELLENCE

UnitedHealthcare, through the Center of Excellence program, has identified certain Hospitals with special expertise in performing the following complex surgical procedures:

- Bone marrow transplants.
- Heart transplants.
- Kidney transplants.
- Liver transplants.
- Lung and heart/lung transplants.

If you are receiving Out-of-Network or No-Network services, you must inform UnitedHealthcare Care Coordination℠ (Out-of-Network: 800-638-7388 or No-Network: 800-527-0764) in advance of these procedures in order to meet the program's pre-notification requirements. After reviewing the case and completing discussions with all the parties involved, UnitedHealthcare Care Coordination℠ may suggest treatment at a Center of Excellence location. The final decision on a treatment location, however, will rest with you and your Physician.

Special Benefits Provided. If you decide to follow the UnitedHealthcare Care Coordination℠ suggestion and seek treatment at a United Resource Network location, you will receive the following special Benefits:

- All facility charges and professional service fees will be 100% covered and the In-Network $100 (per admission) hospital Copay will be waived.
- Annual Deductible and Coinsurance requirements will be waived in relation to the surgery.
- Transportation, food, and lodging expenses for the patient to have the operation will be paid.
- Transportation, food, and lodging expenses for medically necessary preoperative and postoperative trips will be paid.
- Travel and accommodations for one non-medically necessary trip for a companion will be paid ($100/day expense limit and $2,100 total expense limit).
- Expenses for medically necessary companion trips (for example, an adult accompanying a minor child) will be paid.

Tax Treatment

Transportation expenses for medically necessary trips will be non-taxable. Other payments (for example, food, lodging, and non-medically necessary companion trips) will be treated as taxable income.

United Resource Network Locations

Certain facilities throughout the United States have been identified as Center of Excellence. UnitedHealthcare Care CoordinationSM can provide you with a list.

XIII. MENTAL HEALTH CARE AND SUBSTANCE ABUSE TREATMENT PROGRAM

Mental health care and the treatment of substance abuse and chemical dependency are covered separately than other illnesses by the UHC POS benefit option.

This program applies to all participants in the UHC POS benefit option regardless of your Network status (In-Network, Out-of-Network, No-Network).

The Company has contracted with United Behavioral Health (UBH) to manage your mental health and substance abuse Benefits. UBH arranges for your care through an extensive Network of participating providers (which is also referred to as In-Network services throughout this section).

When you call UBH, you will speak with a mental health professional who will assess your situation and then refer you to a participating provider in your area.

The following information will help you understand how to use the program.

Mental Health/Substance Abuse Pre-Notifications

UBH handles emergencies, pre-notifications, and access to care seven days a week, 24 hours a day. They can be reached at 800-842-1219. Care that is not pre-authorized or referred by UBH is not covered (such care is also referred to as Out-of-Network services). Out-of-Network services will be covered as noted below.

In-Network Services

UBH arranges for your care through an extensive Network of participating providers who specialize in mental health and substance abuse treatment. UBH also monitors your treatment to ensure that it is appropriate to your needs.

You will be responsible for services not covered by the program and for the applicable Copays when you receive covered services through a UBH Network provider. *Your Copays cannot be applied to any Deductibles or Out-of-Pocket Maximums.*

Service Received: In-Network	POS Plan	MN/ND & Western WI
Inpatient Mental Health Treatment	$100 per admission/maximum $300 per year, per person. *MN	100%
Outpatient Mental Health Treatment	No Copay for first three sessions; $10 Copay per In-Network outpatient session thereafter.	$10
Inpatient and Outpatient Substance Abuse Treatment	$100 per course of treatment (includes detox), per person. Outpatient: $10 Copay per session.	100% $10

Out-Of-Network Services

Benefits are not available for mental health and substance abuse treatment if you do not pre-authorize and use Network providers referred by UBH. When you are enrolled in the In-Network POS benefit option, you have the

option of going Out-of-Network. Out-of-Network services are available as noted below.

Service Received: Out-of-Network	POS Plan	MN/North Dakota/ Western WI
Inpatient Mental Health Treatment	80% after Deductible.	80% after Deductible
Outpatient Mental Health	80% after Deductible.	80% after Deductible
Substance Abuse Treatment-Inpatient and Outpatient	80% after Deductible.	80% after Deductible

No-Network Services

If you are enrolled in the No-Network benefit option, Benefits are not available for mental health and substance abuse treatment if you do not preauthorize and use Network providers referred by UBH. Out-of-Network services will be covered as noted in the chart below.

Service Received: In or Out-Network	No-Network Plan
Inpatient Mental Health Treatment	
In-Network	$100 per admission/maximum $300 per year, per person.
Out-of-Network	
In and Out-of-Network	100% after Deductible (Network discounts available when referred to a Network provider by United Behavioral Health).
Outpatient Mental Health	
In-Network	No Copay for first three sessions; $20 Copay per session thereafter. Annual Maximum Plan Benefit of up to 40 medically necessary sessions per year, per person.
Out-of-Network	No Benefit provided.
In and Out-of-Network	No Copay for first 3 sessions; 80% after Deductible thereafter.
Substance Abuse Treatment-Inpatient and Outpatient	
In-Network	$100 per course of treatment (includes detox), per person. Maximum Plan Benefit of two courses of treatment per lifetime.
Out-of-Network	
In and Out-of-Network	Inpatient: 100% after Deductible. Outpatient: 80% after Deductible. The maximum of two courses of treatment per lifetime no longer applies.

For questions, concerns, or complaints regarding the program, claims inquiries, or information on Network providers, the participant can call Member Relations at 800-842-1219.

For participants who file a formal written complaint, they will have as their advocate the appeals coordinator in Member Relations who will thoroughly investigate the matter and bring it to resolution. Resolution on formal complaints is communicated in writing within 30 days. You may submit written complaints to:

United Behavioral Health
425 Market Street, 27th Floor
San Francisco, CA 94105-2426
Attn.: Member Relations Department

If Lumen Coverage is Secondary

Even if the Lumen Plan mental health and substance abuse coverage is secondary to other coverage you may have, you must still pre-authorize care through UBH in order to receive Benefits.

Pre-Notification And Case Management

You or your provider must get a referral or pre-notification from UBH before receiving the following services (or within 24 hours in the case of an emergency admission):

- Inpatient care for mental health conditions (Outpatient alternatives must also be pre-authorized. See “Alternatives to Inpatient Mental Health Care Benefits” on page 29).
- Inpatient or outpatient care for substance abuse.
- Outpatient care for mental health condition.

You are responsible for contacting UBH to get a referral or to initially pre-authorize the care discussed above. After this initial pre-notification, a UBH Network provider will pre-authorize any further care for mental health and substance abuse treatment.

The UBH Care Manager will determine the appropriateness of the proposed treatment and certify care for treatment as medically necessary. Expenses for treatment beyond the authorized time will not be paid.

In an Emergency, calling UBH will result in an immediate referral to an appropriate Network facility or provider for evaluation and treatment. If you are unable to pre-authorize at the time of the Emergency, UBH must be notified with 24 hours from the time emergency care is received. All emergency care is subject to review by UBH for medical necessity.

If Pre-Notification Is Denied

For disputes over medical necessity or appropriate level of care with regard to all mental health and substance abuse treatment, there are four levels of appeal. In the first level of appeal, referred to as an expedited appeal, a provider may request immediate reconsideration of a clinical decision and receive telephone consultation from a peer reviewer. All inpatient requests for reconsideration are heard by a member of UBH’s internal psychiatric staff. A decision will be made during the telephone consultation between the provider and peer reviewer.

Should you or your provider wish to appeal the decision, a second level review by a board-certified physician not involved in the supervision of the case may be requested. The appeal must be in writing. All supporting

documentation will be thoroughly reviewed, and a written decision rendered. You will receive a response within 30 days. If your appeal is denied, the written notice will include the reason for denial, reference to the pertinent program provisions, and information on what material would be needed to make your claim acceptable, and instructions on how to receive the next level of review. Should you or your provider wish to appeal the second level review, it must also be in writing.

The third level of appeal is reviewed by another physician not involved in the supervision of the case prior to the appeal review. If you are still not satisfied with the decision, your case may be heard by the Grievance Committee.

The UBH Grievance Committee is composed of UBH administrative and medical staff, provider Network representatives, and customer representatives. Participants and providers may request a hearing before the Grievance Committee whenever a clinical issue cannot be resolved to their satisfaction and all options have been exhausted.

Requests for hearing before the Grievance Committee must be made in writing and submitted to:

United Behavioral Health
425 Market Street, 27th Floor
San Francisco, CA 94105-2426
Attn.: Grievance Committee

When a written request for a grievance hearing is received, the member or provider requesting the hearing will be advised of the next regularly scheduled meeting. Additional records or documents may be requested to allow full investigation into the issues. You will be responsible for any costs associated with making your medical records available for review. Decisions are reached by majority vote and communicated in writing within 30 days following the hearing. The decision of the Grievance Committee is the final step in the formal appeals and grievance process.

Note: During a hospital stay, concurrent recommendations for continued hospital stay and other treatment are not considered final and are not subject to appeal until discharge. At that time, a written request for review of any non-certified services should be submitted to UBH and any appeals may be pursued.

Emergency Situations

An emergency is an unforeseen behavioral disorder, chemical dependency, or psychological injury that requires clinical attention within 24 hours in the absence of which the participant could be expected to suffer serious physical or psychological impairment or death or be a danger to oneself or others.

Medically Necessary

This means that a particular service is consistent with the treatment of a participant's behavioral disorder, substance abuse, or psychological injury; warranted by the treatment as described in the guidelines for level of care on file at UBH; not solely for the convenience or preference of the participant or the health care provider; and the least restrictive and least intrusive appropriate supply or level of service, which can be safely provided to the participant. Services provided on an inpatient basis are medically necessary only in instances where the symptoms or conditions require treatment that cannot be safely provided on an outpatient basis.

Although you and your physician/provider ultimately determine the treatment you receive, the program covers only services that UBH determines in their judgment to meet the program's requirements of medical necessity.

Inpatient Mental Health Care Benefits

In the case of an Emergency, you must call UBH within 24 hours from when emergency care is received. Long-term care (such as Custodial Care) is not covered by inpatient Benefits.

If you are hospitalized without pre-notification, your claim will be denied. There are no Benefits available for care that is not pre-authorized by UBH.

If you are hospitalized without pre-notification, a $250 notification penalty will apply. Out-of-Network services will be covered at the Out-of-Network level of Benefits noted in the charts above.

Covered Facilities

Inpatient care is covered if given in a hospital, a psychiatric hospital, or a substance abuse treatment facility. Any facility must be state-licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

Covered Providers

Covered providers (inpatient and outpatient) include state-licensed psychiatrists, psychologists, social workers, and other licensed master's level providers who have entered into a contract with UBH to provide covered services to participants.

Alternatives to Inpatient Mental Health Care Benefits

Medically necessary alternative levels of treatment to inpatient care such as partial hospitalization, intermediate and day treatment are also covered with care manager approval. If the care manager determines that alternative levels of care are appropriate, coverage may be authorized. Any alternative levels of care can be used in lieu of acute inpatient care.

Such alternative care must meet the following conditions:

- The program must be state-licensed and meet UBH's standards.
- Therapeutic services must be similar to those offered in a psychiatric hospital.
- Treatments must last from 3 to 12 hours.

Intensive outpatient care (which is in lieu of inpatient hospitalization) is considered a period of crisis intervention involving visits on two or more days per week for the duration of the crisis. This care is based on the inpatient Benefit noted in the charts above.

Outpatient Mental Health Care

Outpatient mental health care Benefits generally apply to any medically necessary mental health care that does not qualify for inpatient coverage (or as an alternative to inpatient coverage).

In order to receive Benefits for outpatient mental health care, you must contact UBH to get a referral to a UBH Network provider. If you receive treatment from a UBH provider without being referred by UBH, you will be responsible for any expenses incurred with that provider.

Outpatient Sessions

A session, for purposes of outpatient mental health care Benefits, is defined as one hour or less.

Substance Abuse Treatment

**** for those residing in MN, ND and Western WI please refer to the above Chart related to Substance Abuse***

Treatment for medically necessary inpatient and outpatient substance abuse is covered at 100%, based on the UBH Network fee schedule, after a Copay of $100 per course of treatment. If a participant ceases receiving treatment for a period exceeding 30 days, any further treatment constitutes a separate course of treatment and would require an additional $100 Copay.

To receive inpatient or outpatient substance abuse Benefits, your treatment must be medically necessary, must be provided by UBH Network provider, and you must obtain pre-notification from a UBH Care Manager. Out-of-Network services will be covered as noted in the charts above.

Course of Treatment

The continuous treatment of a participant through assessment, detoxification, inpatient and outpatient treatment, and after care.

Filing A Service Claim

If you are referred and pre-authorized to be treated by a provider in the UBH Network, your claim will be filed with UBH by the Network provider.

There may be a few circumstances where you would personally need to file a claim form with UBH (for example, participants living outside of the U.S.). In those cases, claim forms can be obtained by calling UBH. Claims should be mailed to the address on the UBH claim form.

XIV. PREVENTIVE CARE & WELLNESS

You and your covered dependents are eligible for a variety of wellness Benefits.

Because early detection of disease and the recognition of health risk factors can be so important in keeping you and your Dependents healthy, the UHC POS benefit option covers a variety of wellness procedures. Eligibility is based on the age of the participant.

In-Network services. Are covered 100% after a $10 (per visit) Copay. *if you are residing in MN, ND and Western Wisconsin please reference the chart above. Your PCP will determine the appropriate preventive services. No schedules will dictate your coverage, but this section gives you an idea of the guidelines your PCP will follow. If a Physician approves services, which UnitedHealthcare later decides was inappropriate, you will not be responsible for the charges over your Copay.

No-Network and Out-of-Network services. Are covered at 100% based on an analysis of Eligible Expenses fees and are not subject to a Deductible. All eligible wellness services are listed in this section.

High-Risk Individuals

If your Physician certifies that you are at high risk, the program's wellness coverage will also apply to HIV testing for the AIDS virus and other tests approved by UnitedHealthcare Care Coordination℠ as well as immunizations for hepatitis B and pneumococcal influenza, and influenza vaccines.

Adult Health Screenings (Out-Of-Network And No-Network)

Office visit charges for a basic preventive office visit and periodic screening tests (listed in the following table) are covered only as the charges relate to those covered services. Diagnostics, lab tests, and X-rays not listed in the table will not be covered if performed on a routine basis, as described below.

18 through 39 years	Ten preventive office visits at two-year intervals, and: • Five cholesterol tests at four-year intervals. • Ten pap smears, breast exams, and hemoglobin tests at two-year intervals. • One baseline mammogram between ages 35 and 40. • One tetanus booster every ten years. • Measles, mumps, and rubella immunizations if at high risk. • Chicken pox immunization.
40 through 49 years	Five preventive office visits at two-year intervals, and: • Three cholesterol tests at four-year intervals. • Five pap smears, breast exams, and hemoglobin tests at two-year intervals. • Five mammograms at two-year intervals. • Five occult blood tests at two-year intervals. • One tetanus booster every ten years. • Chicken pox immunization.
50 years and older	Preventive office visit at two-year intervals and screenings consisting of: • Cholesterol tests at two-year intervals. • Pap smear, breast exam, and hemoglobin test annually. • Mammogram annually. • Occult blood test annually. • Sigmoidoscopy-annually for two years, then at three-year intervals. • One tetanus booster every ten years. • Chicken pox immunization. • Prostate specific antigen (PSA) testing.

Note: Only completed, not partial, years will be used to measure age. A participant's age will change on the first day of the month following that participant's birthday.

Well Child Care (Out-Of-Network and No-Network)

Office visit charges for a basic preventive office visit and periodic immunization (listed in the following table) are covered only as the charges relate to those covered services. Diagnostics, lab tests, and X-rays not listed in the table will not be covered if performed on a routine basis, as described below:

0 (under 1 year)	Five preventive office visits to learn about proper diet, Injury prevention, and other primary prevention measures. These visits will also cover: • Three rounds of immunizations at two, four, and six months. • Vaccines: diphtheria, tetanus, pertussis, trivalent polio; and pneumococcal. • Four hemophilus influenza Type B immunizations.
1 through 2 years	Four preventive office visits with physical exams and immunizations for: • Pneumococcal vaccine between 12 and 15 months. • Measles, mumps, and rubella at 15 months. • Diphtheria, tetanus, and pertussis at 15 months. • Trivalent polio at 15 months. • Hemophilus influenza Type B (2 per year). • Chicken pox.

3 through 17 years	Eight preventive office visits with a physical exam, a health risk assessment, and a risk modification plan for diet and exercise, substance abuse, sexual practices, Injury prevention, and dental health, and: • Pap smear every two years for females who are sexually active. • Immunizations for: • Diphtheria, tetanus, and pertussis at age five. • Diphtheria-tetanus at age 15 and every ten year thereafter. • Trivalent polio vaccine at age five. • Tuberculin test at age five. • Chicken pox, measles, mumps, and rubella.

Note: Only completed, not partial, years will be used to measure age. A participant's age will change on the first day of the month following that participant's birthday.

Hearing Loss/Testing

You and your covered dependents are eligible for tests to detect hearing loss and services to correct hearing loss.

Hearing loss/testing is covered for all UHC POS participants once during any 36-month period. A maximum of $50 will be provided for a hearing exam by a Physician or licensed audiologist and up to $300 for prescribed hearing equipment, including:

- Cords and ancillary equipment.
- Ear molds.
- Hearing aid instruments.
- Initial batteries.
- Initial warranty.
- One follow-up consultation within 30 days of buying the equipment.

If you have additional expenses, they do not count toward any Copays, Deductibles, or Out-of-Pocket Maximums.

In order to be considered covered expenses under this provision, the eligible services or equipment cannot be covered in whole or in part by any other provision of this program, other than a Health Care Flexible Spending Account.

XV. PRESCRIPTION DRUG PROGRAM

In addition to your regular coverage, the UHC POS benefit option provides economical sources for prescription drugs.

This program applies to all participants in the UHC POS benefit option regardless of your Network status (In-Network, Out-of-Network, No-Network).

You're eligible to participate in the Prescription Drug Program if you're enrolled in the UHC POS benefit option. The program is administered by UHC Pharmacy Management and offers two ways to purchase prescription drugs:

- Retail. Use your ID card at a participating pharmacy for emergency medication and short-term prescription needs.
- Mail-Service. Use this Benefit for long-term prescription needs

Retail Pharmacy Program

Through the UHC Pharmacy Management program, you can purchase prescription drugs needed on a short-term basis at one of the more than 50,000 participating chain and independent pharmacies. To use the

program, present your UHC ID card at the participating pharmacy and pay the required Copay, as follows:

	ERO/ Choice Plus Network) and No-Network 34 Day Supply	ERO (MN/ND & Western WI) 30-day Supply
Generic	$5	$5
Brand Name	$10	$12

You won't be reimbursed for the prescriptions you purchase if:

- You have access to but don't use a participating pharmacy.
- You don't use your UHC ID card at a participating pharmacy.

Mail-Service Program

You have the option of using the OptumRx Home Delivery Program to save money on covered maintenance prescription drugs. Participation is optional. The cost for up to a 90-day supply of maintenance medication is $5 per generic prescription and $10 per brand-name prescription. ***If you are residing in MN, ND and Western WI you have a flat $5 copay for mail order only through OptumRx Home Delivery Program.*** If you're unsure whether the prescription is generic or brand name, submit $10. If the prescription is generic, the $5 overpayment will be applied as a credit toward your next purchase, or you may request a refund by calling OptumRx Home Delivery Program. If you pay only $5 for a brand-name prescription, your prescription may be delayed until you pay the full $10.

If you choose to order maintenance medication through OptumRx Home Delivery Program, take the following steps:

- If you have an immediate need, ask your Physician to give you two prescriptions-one for 30-day supply and one for up to a 90-day supply. Have your local pharmacy fill the 30-day prescription while the mail-service order is in transit.
- Complete the Health, Allergy, and Medication Questionnaire (with your first order only).
- Complete the OptumRx Home Delivery Program (Forms are available by calling customer service or going online to myuhc.com).
- Enclose your prescription(s) and the appropriate Copay for each prescription in the OptumRx Home Delivery Program By Mail Order Form.
- Mail the envelope to: OptumRx, P.O. BOX 2975, Mission, KS, 66201

ePrescribe:

Your doctor can send an electronic prescription to OptumRx

By mail. Mail your prescription and required Copayment along with an order form.

Refills through the mail-service program can be ordered online, by phone, or by mail.

Refills.

- **Refills online**: Log onto the web site at myuhc.com. First time visitors must register on this site. Have your ID number located on your UHC ID card, prescription number, and credit card number ready.
- **Refills by phone**: Just call the member phone number on your plan ID card to talk with a customer service representative right now. It's helpful to have your plan ID card and medication bottle available. The representative can also contact your doctor directly if you need a new prescription.
- **Refills by mail**: Use the refill order forms provided with your medication. Mail the refill order forms with your Copayment.

The medication will be sent to your home by first-class mail or UPS, usually within ten to 14 days.

This program does not coordinate Benefits with any other plans. Your drug Copays can't be applied toward other program Deductibles or Out-of-Pocket Maximums.

Drugs that are covered or excluded under the Prescription Drug Program are listed in the Eligible and Ineligible Expenses section.

XVI. OTHER PLAN FEATURES

Managed Rx Coverage

Managed Rx Coverage is a program designed to manage the utilization of certain categories of drugs. It limits coverage for improper use of medications prescribed for certain conditions that are prone to abuse or misuse. The program helps the Company improve the quality of care by requiring adherence to generally accepted prescribing guidelines for coverage.

If you present a prescription at the pharmacy and the drug does not meet the criteria established for the prescription, the pharmacist will be given a phone number that can be called in order to initiate a coverage review. The patient, pharmacist, or Physician can initiate this review process.

The pharmacist will also be advised if a different quantity of the drug can be dispensed at that time. The patient can either initiate a coverage review, get a reduced quantity of the medication, if appropriate, or wait until a review is completed.

If the patient utilizes the mail-service to fill their prescription and it does not meet the criteria, one of the following will occur:

- The prescription will be filled for the amount allowed and sent to the patient with a note explaining how to obtain a coverage review.
- The prescription will be returned to the patient unfilled with a note explaining that the medication will not be covered as written and with instructions on how to obtain the medication.
- A coverage review will be initiated for certain drugs in the program, and if the patient meets the coverage review criteria the prescription will be filled. If criteria is not met, the prescription will be returned to the patient unfilled with a note explaining why.

Prior Authorization

Managed Prior Authorization is a program to manage coverage for certain drugs to prevent usage outside the scope of the pharmacy Benefit. For this reason, some medications must receive prior authorization from UHC Pharmacy Management before they can be covered under your Benefit plan. If the prescribed medication must be pre-authorized, your pharmacist will inform you. The pharmacist may initiate the review process, or you may request your Physician to call a toll-free number that will be supplied by your pharmacist. This process typically takes two business days. The patient and the Physician will be notified when the review process is completed. If your medication is not approved for coverage, you will have to pay the full cost of the drug.

If the patient utilizes the mail-service to fill their prescription, a coverage review will be initiated and, if the patient meets the coverage review criteria, the prescription will be filled. If the drug does not meet the criteria, the prescription will be returned to the patient unfilled with a note explaining why.

XVII. ELIGIBLE AND INELIGIBLE EXPENSES

Covered Drugs

Federal legend drugs (drugs with an FDA number posted on the prescription label) are available with the following additions and restrictions:

- Injectables.
- Insulin (including syringes and over-the-counter diabetic supplies).
- Oral and injectable contraceptives.
- Ostomy supplies (covered under mail-service only).
- Retin A (excludes use for cosmetic purposes).
- Smoking deterrents (covered under mail-service only-three-month maximum supply, three times per lifetime).

  Smoking deterrents will only be dispensed if the prescription is attached to a letter from the Physician describing the behavior modification/educational programs the participant is undergoing to assist with smoking cessation. The program should be sponsored by, or similar to that of, the American Lung Association.

Excluded Drugs

Excluded drugs include, but are not limited to:

- Allergy sera.
- Biological sera, blood, or blood plasma products.
- Contraceptive devices, jellies, creams, foams, or implants.
- Drugs for cosmetic purposes or to stimulate hair growth.
- Drugs purchased at a Non-Network pharmacy.
- Drugs for weight loss.
- Durable Medical Equipment.
- Experimental or investigational or Unproven drugs.
- Fertility agents
- Food supplements.
- Free drugs (received without charge as a result of Workers' Compensation laws or from municipal, state, or federal programs).
- Growth hormones.
- Immunization agents.
- Methadone.
- Non-legend drugs other than insulin.
- Over-the-counter drugs.
- Prescription drugs with an over-the-counter equivalent.
- Replacement of lost or stolen drugs.
- Therapeutic appliances.
- Any prescription refilled in excess of the number of refills specified by the Physician, or any refill dispensed after one year from the Physician's original order.
- Any drug provided while covered as an inpatient in any health care facility including licensed Hospitals, rest homes, extended care facilities, skilled nursing facilities, nursing homes, or similar institutions which operate on their premises a facility for dispensing pharmaceuticals.

See "WHAT THE PROGRAM DOES NOT COVER" on page 36 for other coverage exclusions.

XVIII. HOW TO CONTACT OptumRx

On The Internet: myuhc.com. Learn about patient care, refill and renew Home Delivery prescriptions, check the status of your order, view 12 months of prescription history, request claim forms, Home Delivery order forms, additional ID cards for family members or find a participating retail pharmacy near you.

By Telephone: Just call the member phone number on the back of your plan ID card to talk with a customer service representative. It's helpful to have your plan ID card available at the time of the call.

XIX. WHAT THE PROGRAM DOES NOT COVER

The UHC POS benefit option helps you pay for most medical expenses, but it does not cover the items listed here.

Certain types of medical services and supplies, and services for certain conditions are not within your medical coverage, nor can payments for such services be used to satisfy your Deductibles or Out-of-Pocket Maximums.

Generally, charges for services and supplies not found by UnitedHealthcare or UBH, as appropriate, to be medically necessary are not covered. Also, any charges for services and supplies rendered before your coverage becomes effective under this program are not covered.

Certain excluded hospital charges are listed in the Hospitalization and Alternatives section. Other services and expenses not covered by your program include, but are not limited to:

- Air conditioners and fresheners.
- Athletic club dues.
- Automobile accident injuries to the extent auto insurance coverage is available (claims must be filed with auto insurance before payment under the program will be considered).
- Autopsy charges.
- Blood pressure kits (except for dialysis patients).
- Charges for which you have no legal obligation to pay.
- Child's stroller.
- Claim form completion charges.
- Cosmetic surgery (unless medically necessary).
- Custodial care or services provided by a personal care assistant.
- Cytotoxic food testing.
- Dental care not specifically covered in the medical section.
- Diagnostic studies (except wellness procedures described in the Wellness section) which do not reveal an Illness or Injury, unless there is satisfactory proof of a definite symptomatic condition requiring medical attention.
- Educational programs.
- Elevators or escalators for the home.
- Embryo transfer procedures.
- Employment-related Injuries or Illnesses for which the employer would provide payment.
- Entral feedings with exclusion of metabolic conditions and cystic fybrosis
- Equipment such as scales, ice bags, heating pads, thermometers, overbed tables, vaporizers, vibrating devices, and humidifiers (except those used with oxygen units).
- Exercise equipment.
- Experimental and Investigational, or Unproven Services
- Experimental treatments, including surgery, drugs, food supplements, and vitamins, as identified by UnitedHealthcare.
- Foot care (except for diabetics).

- Gastric bubbles and balloons.
- Genetic counseling.
- Hypo-allergenic cosmetics or toiletries.
- Infertility treatments.
- Injuries related to the commission of a crime.
- Inoculations, immunizations, booster shots, etc. (except for wellness procedures described in the Wellness section).
- Late claims (submitted later than 15 months after the services were rendered).
- Massage therapists.
- Mattresses (except as part of a hospital bed).
- Nursing homes, convalescent homes, homes for the aged, or other care primarily custodial in nature.
- Occupational illness or Injury arising out of or in the course of employment.
- Orthodontia even if related to an accident, except that orthodontia is covered for a cleft lip or cleft palate for covered newborn and adopted children of participants residing in a UnitedHealthcare Network area of Colorado.
- Personal service charges for hospitalized patients (television rental, guest meals, etc.).
- Prescription drugs (except as provided under the Prescription Drug Programs).
- Private-duty nursing.
- Radial keratotomy and similar procedures.
- Services that would be provided without charge in the absence of the program.
- Sex transformation operations.
- Standby availability charges for Physicians and Hospitals.
- Swimming pools, hot tubs, spas, or pool heaters.
- Temporomandibular joint dysfunction non-surgical procedures.
- Thermography (except as a covered chiropractic practice).
- Travel expenses (except for those approved through the United Resources Network program).
- Uncovered provider charges.
- Vitamins and food supplements.
- Weight-reduction programs (exercise sessions and related nutritional therapy).
- Wigs and wig styling.

UnitedHealthcare and UBH have the discretion to approve a variety of services and supplies. The absence of such approval is grounds for excluding coverage.

XX. SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. The terms of this entire subrogation and reimbursement provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the Covered Individual identifies the medical/dental benefits the Plan advanced. The Plan's right of full reimbursement shall not be reduced or limited in any way by the Covered Individual's actual or alledged comparative fault or contributory negligence in causing the injury(ies) or accident for which the Plan advanced medical/dental benefits.

XXI. CLAIMS DENIALS AND APPEALS

If Your Claim is Denied

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

When appealing a denied claim, please be aware that there are Service Claim appeals processed by the Claims Administrator (UHC) as well as Eligibility/Participation appeals processed by the Plan Administrator. Both types of appeal have two levels of appeal processing each with their own requirements as described below.

How to Appeal a Denied Service Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your Level 1 appeal in writing within 180 days of receiving the claim denial which is also called an “adverse benefit determination”. You do not need to submit Urgent Care appeals in writing. Your appeal of a denied claim should include:

- the patient’s name and ID number as shown on the ID card;
- the provider’s name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.
- **Note:** If you are appealing an excluded drug, submit a letter to UHC from your doctor stating the medical condition that requires the non-covered drug and the length of projected use. The appeal will be reviewed and, if approved, you will be able to purchase your prescription at your local

  network pharmacy or by mail order by paying the applicable Coinsurance amount. If it is denied, you may appeal as explained below.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare Self-Insured - Appeals
Box 30432
Salt Lake City, Utah 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call the Claims Administrator (UHC) at the Customer Service phone number on the back of your ID card to request an appeal.

Types of claims

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

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

Review of an Appeal

The Claims Administrator (UHC) will conduct a full and fair review of your appeal. The appeal may be reviewed by:

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

Once the review is complete, if the Claims Administrator (UHC) upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

There are two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator (UHC) within 60 days from receipt of the first level appeal determination.

Note: *Upon written request and free of charge, you may request to examine documents relevant to your claim and/or appeals and submit opinions and comments. The Claims Administrator (UHC) will review all claims in accordance with the rules established by the U.S. Department of Labor.*

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator (UHC), or if the Claims Administrator fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Claims Administrator (UHC)'s determination. You may request an external review of an adverse benefit determination if the denial is based upon any of the following:

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

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. **Please Note this Deadline:** A request must be made within four (4) months after the date you received the Claims Administrator (UHC)'s decision.

An external review request should include all of the following:

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

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

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

Standard External Review

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

- a preliminary review by the Claims Administrator (UHC) of the request;
- a referral of the request by the Claims Administrator (UHC) to the IRO; and
- a decision by the IRO.

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

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

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

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

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

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

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

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

Expedited External Review

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

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

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for

an expedited internal appeal; or

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

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

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

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

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

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

Timing of Appeals Determinations

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

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

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

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

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
The Claims Administrator (UHC) must notify you of the appeal decision within:	**72 hours** after receiving the appeal

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

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

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

Concurrent Care Claims

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

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

Eligibility/Participation Claim

After you receive an initial denial of a submitted claim, there are two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator (UHC) within 180 days from the receipt of the first level appeal determination. The below Table outlines both the timeline for filing an appeal by you and for receiving responses from the Claims Administrator (UHC).

Eligibility/Participation Claims	
Type of Request for Benefits or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator (UHC) must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator (UHC) within:	**45 days**
You must then provide completed request for Benefits information to the Claims Administrator (UHC) within:	**45 days**
The Claims Administrator (UHC) must notify you of the benefit determination:	
• if the initial claim is complete, within:	**30 days**
• after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination (file a first level appeal) no later than:	**180 days** after receiving the adverse benefit determination
The Claims Administrator (UHC) must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**180 days** after receiving the first level appeal decision
The Claims Administrator (UHC) must notify you of the second level appeal decision for eligibility/ participation claim within:	**60 days** after receiving the second level appeal (up to an additional 30 days may be required if necessary)

Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit.

The Health Plan provides that no person has the right to file a civil action, proceeding or lawsuit against the Health Plan or any person acting with respect to

the Health Plan, including, but not limited to, the Company, any Participating Company, the Committee or any other fiduciary, or any third party service provider unless it is filed within the timing explained as follows below:

Initial Claim: The time frame for filing an initial claim for a premium Payroll Adjustment is the earlier of:

1. Within 180 days of an adverse decision by the Plan Administrator, or
2. The earlier of:

a. Within 180 days of the effective date of an election that is later claimed to be erroneous, or

b. By the last day of the Plan Year of when the election error is claimed to have occurred. If the initial claim is not filed by this deadline, it shall be deemed untimely and denied on that basis. Appeals from a claim denial must also be timely filed as described in the Summary Plan Description.

Agent for Service of Legal Process:

Chief Privacy Officer
931 14th Street, 9th Floor
Denver, CO 80202

Legal process may also be served on:

CT Corporation System
7700 East Arapahoe Road
Suite 220
Centennial, CO 80112

Legal Action Deadline: After you have exhausted or completed the claims and appeals procedures as explained above, you may pursue any other legal remedy, such as bringing a lawsuit or civil action in court provided, that you file a civil action, proceeding or lawsuit against the Plan or the Plan Administrator or the Claims Administration no later than the last day of the twelfth month following the later of (1) the deadline for filing an appeal under the Plan or (2) the date on which an adverse benefit determination on appeal was issued to you with respect to your Plan benefit claim.

This means that you cannot bring any legal action against the Plan, the Employee Benefits Committee or the Claims Administrator (UHC) for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action, you must do so no later than the last day of the 12th month from the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator (UHC).