Lumen Retiree and Inactive Health Care Plan

Consumer Driven Health Plan (CDHP)

(Administered by UnitedHealthcare)

Summary Plan Description (SPD)
For Retired and Inactive Former Retirees

CenturyLink, Embarq, Qwest Post-1990 Management, Qwest Post 1990 Occupational Retirees (including Inactive and COBRA Participants)

Effective January 1, 2023

This SPD must be read in conjunction with the *Retiree General Information SPD*, which explains many details of your coverage and provides a listing of the other Benefit options under the Plan.

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).

Issued Jan. 1, 2023

LUMEN®

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INTRODUCTION

Lumen Technologies (hereinafter "Lumen" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD presents an overview of the Benefits available under the UnitedHealthcare ("UHC") Self-funded Premium Consumer Driven Health Plan ("CDHP"), including prescription drugs, benefit option of the **Lumen Retiree and Inactive Health Care Plan*** (the "Plan"). This Plan also has a ***Health Reimbursement Account (HRA) component*** that is administered by UnitedHealthcare.

This SPD must be read in conjunction with the Retiree General Information SPD which explains many details of your coverage and provides a listing of the other benefit options under the Plan.

The effective date of this updated SPD is January 1, 2023. If you are a Covered Person in the CDHP Plan benefit option of the Plan on or after January 1, 2023, this SPD supersedes and replaces, in its entirety, any other previous printed or electronic SPD describing medical plan Benefits that you currently may possess. 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 Summary of Material Modifications (SMMs), the *Retiree 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 and Inactive Health Care Plan*. These documents make up your official Summary Plan Description for the CDHP Plan benefit option as required by the Retiree Retirement Income Security Act of 1974, as amended ("ERISA"). This CDHP Plan medical benefit option (including the HRA funds) and the prescription drug Benefits under the Plan are self- funded; however, certain other benefit plan options under the Plan may be insured.

The Patient Protection and Affordable Care Act Known as the "Affordable Care Act"

As a standalone retiree health care plan, the Lumen Retiree and Inactive Health Care Plan* is exempt from the requirements of the Patient Protection and Affordable Care Act ("PPACA" or "Affordable Care Act"). While the Company has decided to voluntarily comply with certain provisions of PPACA, this voluntary compliance does not waive the Plan's exempt status. The Company may choose in its sole discretion to no longer apply these provisions at any time.

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan does provide minimum essential coverage. In addition, The Affordable Care Act establishes a minimum value standard of benefits to a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

This SPD is for eligible former Lumen, CenturyLink (including the Qwest Represented) Retired and Inactive Former Retirees. Active Retirees should refer to their own applicable Lumen Health Plan SPDs, with distinct terms and conditions.

Company's Reserved Rights

The company reserves the right to amend or terminate any of the Benefits provided in the Plan – with respect to all classes of Covered Person, retired or otherwise – without prior notice to or consultation with any Covered Person, subject to applicable laws and if applicable, the collective bargaining agreement.

The Plan Administrator, the Lumen Retiree Benefits Committee, and its delegate(s), has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan and all benefit options— 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 (UHC), shall be conclusive and binding on all persons. More information about the Plan Administrator and the Claims Administrator (UHC) can be found in the General Information SPD.

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 benefit premiums 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* **"Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit."** *in this SPD and 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 and a final decision has been made by the Plan Administrator, if an Eligible 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

The SPD is designed to provide you with a general description, in non-technical language of the Benefits currently provided under the CDHP benefit option without describing all the details set forth in the *Plan Document*. The SPD is not the *Plan Document*. Other important details can be found in the *Plan Document* and the *Retiree General Information SPD*. The legal rights and obligations of any person having any interest in the Plan are determined solely by the provisions of the Plan. If any terms of the *Plan Document* conflict with the contents of the SPD, the Plan Document will always govern.

Capitalized terms are defined in the **"GLOSSARY MEDICAL"** and **"GLOSSARY – PRESCRIPTION DRUGS"** and/or throughout this SPD and in the *Retiree General Information SPD*. All uses of "we," "us," and "our" in this document, are references to 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.

You are encouraged to keep all the SPDs and any attachments (summary of material modifications ("SMMs"), amendments, Summaries of Benefits Coverage, Annual Enrollment Guides and addendums) for future reference. Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.

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 *Retiree General Information SPD* for more information as noted in the **"GENERAL PLAN INFORMATION"** section and throughout this document.

Exempt Retiree Medical Plan Status Notice

The Retiree and Inactive Health Plan (the "Plan") meets the requirements of a stand-alone exempt retiree medical plan under the Section 732 of ERISA and therefore is not required to comply with the Patient Protection and Affordable Care Act (PPACA). However, has decided to voluntarily apply certain provisions of the PPACA to certain benefit options. For example, is making coverage available to the end of the month in which your adult child(ren) attains the age of 26, provided such individual is not otherwise eligible for coverage under another group plan such as one offered by the child's employer. This means that for all Retirees, this voluntary application of PPACA may be changed or ended at any time and does not waive the Plan's status as "exempt" from PPACA.

Health Plan Coverage is Not Health Care Advice

Please keep in mind that the sole purpose of the Plan is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Retiree, Retiree, or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean it is approved or payable under the Plan. A determination by the Claims Administrator (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 the Claims Administrator (UHC) or the Plan Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice.*

Lumen's right to use your Social Security number for administration of benefits

Lumen retains the right to use your Social Security Number for benefit administration purposes, including tax reporting. If a state law restricts the use of Social Security Numbers for benefit administration purposes, the company generally takes the position that ERISA preempts such state laws.

GENERAL PLAN INFORMATION

The CDHP benefit option is just one benefit option offered under the Plan. This SPD must be read in conjunction with the *Retiree General Information SPD* which explains details of your coverage and provides a listing of the other benefit options under the plan.

Refer to the *Retiree General Information SPD* for important and general Plan information including, but not limited to, the following sections:

- Eligibility
- When Coverage Begins
- When Coverage Ends
- 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
- General Administrative Provisions
- Required Notice and Disclosure
- Glossary of Defined Terms
- Qualified Medical Child Support Order (QMCSO)

You can go online at lumen.com/healthbenefits to obtain an electronic copy or call the Lumen Health and Life

Service Center at **833-925-0487** or **317-671-8497** (International callers) or **800-729-7526**, option 2 and option 1 to request a paper copy of the *Retiree General Information SPD*.

You May Not Assign Your Benefits to Your Provider

Participants and Eligible Dependents may not voluntarily or involuntarily assign to a physician, hospital, pharmacy or other health care provider (your "Providers") any right you have (or may have) to:

1. receive any benefit under this Plan,
2. receive any reimbursement for amounts paid for services rendered by Providers, or
3. request any payment for services rendered by Providers.

The Plan prohibits Participants and Eligible Dependents from voluntarily or involuntarily assigning to Providers any right you have (or may have) to submit a claim for benefits to the Plan, or to file a lawsuit against the Plan, the Company, the Plan Administrator, the Claims Administrator (UHC), the appeals administrator or any other Plan fiduciary, administrator, or sponsor with respect to Plan benefits or any rights relating to or arising from participation in the Plan. If Participants and Eligible Dependents attempt to assign any rights in violation of the Plan terms, such attempt will be not be effective. It will be void or otherwise treated as invalid and unenforceable.

This Plan provision will not interfere with the Plan's right to make direct payments to a Provider. However, any direct payment to a Provider is provided as a courtesy to the Provider and does not effectuate an assignment of Participants' and Eligible Dependents' rights to the Provider or waive the Plan's rights to enforce the Plan's anti-assignment terms. Any such direct payment to a Provider shall be treated as though paid directly to Participants and Eligible Dependents and shall satisfy the Plan's obligations under the Plan.

Consequences of 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, which is in violation of the Code of Conduct and may result in disciplinary action, up to and including termination of employment. This misrepresentation/ omission is also 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 Lumen Health and Life 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 Retiree General Information SPD as applicable.

You Must Follow Plan Procedures

Please keep in mind that it is very important for you to follow the Plan's procedures, as summarized in this SPD, in order to obtain Plan Benefits and to help keep your personal health information private and protected. For example, contacting someone at the Company other than the Claims Administrator (UHC) or Plan Administrator (or their duly authorized delegates) in order to try to get a Benefit claim issue resolved is not following the Plan's procedures. If you do not follow the Plan's procedures for claiming a Benefit or resolving an issue involving Plan Benefits, there is no guarantee that the Plan Benefits for which you may be eligible will be paid to you on a timely basis, or paid at all, and there can be no guarantee that your personal health information will remain private and protected.

Plan Number

The Plan Number for the Retiree and Inactive Health Care Plan is 511.

CLAIMS ADMINISTRATOR (UHC) AND CONTACT INFORMATION

The Claims Administrator (UHC)'s customer service staff is available to answer your questions about your coverage Monday through Friday: 8:00 AM – 8:00 PM (all time zones). Hours are subject to change without prior notice.

United Healthcare Customer Service Telephone Numbers (including HRA questions)	**800-842-1219** *(UHC)* *TDD Dial 711 for Telecommunications Relay Services*
United Healthcare Website	You are encouraged to visit myuhc.com to take advantage of several self-service features including: viewing your claim status and finding In-Network Physicians in your area.
Well Connected (case management) *You are responsible for some Prior Authorizations—please refer to the* **WELL CONNECTED RESOURCES TO HELP YOU STAY HEALTHY** *section of this SPD.*	**Prior Authorization** is required **before** you receive certain Covered Health Services. Contact Well Connected at the toll-free Customer Service number shown on your medical ID card **before** receiving these services. References to *Prior Authorizations will be noted throughout this SPD* for additional information.
Mental Health/Substance Use Disorder Optum Behavioral Health	To obtain mental health/substance use disorder Prior Authorization or to contact a care manager (available seven days a week, 24 hours a day), contact Optum Behavioral Health at **800-961-9378** (TDD line Dial 711 for Telecommunications Relay Services).

United Healthcare Mailing Address	**Medical Claims:** To file medical claims, mail the claim form to: United Healthcare Services, Inc. Attention: Claims P. O. Box 30555 Salt Lake City, UT 84130-0884 **Medical Appeals/Complaints:** To file a medical appeal for UnitedHealthcare, mail the appeal to: UnitedHealthcare Attn: Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 **Mental Health/Substance Use Disorder 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: Optum Behavioral Health Attn: Member Relations Department 425 Market Street, 27th Floor San Francisco, CA 94105-2426 **Prescription Drug Appeals:** To file a prescription drug appeal, mail the appeal to: UnitedHealthcare Attn: Appeals P.O. Box 30432 Salt Lake City, UT 84130-0432 For more information on how to appeal a claim, refer to **"CLAIMS PROCEDURES"**. **HRA Claims and Appeals:** Health Care Account Services Center P.O. Box 981506 El Paso, TX 79998-1506
Prescription Drug Program OptumRx (including mail order refills)	For information regarding Prescription Drugs call 800-842-1219 or myuhc.com Refer to the **"PRESCRIPTION DRUGS"** section later in this SPD for more information.

Consumer Solutions and Self-Service Tools

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

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

You are encouraged to visit myuhc.com to take advantage of several self-service features including: viewing your claim status and finding In-Network Physicians in your area.

With myuhc.com (as identified on the back of your ID card) you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;

- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the health cost estimator to obtain an estimate of the costs of various procedures in your area; and use the Hospital comparison tool to compare Hospitals in your area onvarious patient safety and quality measures.
- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card; or
- View your account balances (HRA, FSA and HSA, etc.)
- Connect directly to UHC for answers to benefit questions
- Review hospital quality and safety data
- Check for lower cost drug alternatives
- Manage prescriptions
- Access maps and driving directions to providers offices
- Want to Learn more about a condition or treatment?
- Log on to myuhc.com and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

UNITEDHEALTHCARE CDHP PLAN BENEFIT OPTION (CDHP) allows 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.

UNITEDHEALTHCARE CDHP PLAN BENEFIT OPTION (CDHP)

Eligibility

If you are eligible for medical coverage under the Plan, (refer to the Retiree General Information SPD for more information regarding eligibility under the Plan and other important information), you may have several choices of which medical benefit option to enroll in. To be eligible for the UHC CDHP Plan benefit option, you must live inside of the established UHC ***Choice Plus*** Network. (The Claims Administrator (UHC) has several network choices in which Providers may participate. In most areas, the Claims Administrator (UHC) contracts specifically for the ***Choice Plus*** network for our Network Benefits.) When accessing the Claims Administrator (UHC)'s web site to locate Providers or when speaking with Providers, you should refer to the ***Choice Plus*** Network to make sure that you are accessing the correct Network Providers.

Eligibility to participate in a Health Reimbursement Account (HRA). You must be enrolled in the CDHP benefit option in order to participate in the associated HRA. It is automatically provided to those who enroll in the CDHP and cannot be elected separately. If you change medical benefit options under the Plan, any eligible HRA balance will roll over to another CDHP or HDHP benefit option. See **"HOW TO ACCESS YOUR HRA DOLLARS"** in this SPD for more information.

About the CDHP Benefit Option and HRA

The CDHP benefit option covers;

- hospitalization;
- surgery;
- inpatient and outpatient care;
- diagnostics;
- prescription drugs;
- home health care; and
- a variety of other medical services and supplies as administered by the Claims Administrator (UHC).

Mental Health and Substance Use Disorder Services are administered by Optum Behavioral Health ("OBH"), a division of UnitedHealthcare.

The CDHP benefit option also includes a number of medical cost and care management features such as Provider Networks (including PremiumSM Tier Providers and Freestanding Facilities) and Designated Facility or Centers of Excellence networks for specialized care requiring Prior Authorization. You typically experience lower out-of-pocket expenses by using Network Providers.

By aggressively working to contain medical care costs while also maintaining quality service, the Company helps to keep high-quality medical care available for you and your Dependents.

The CDHP 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 Deductibles, Coinsurance, and Out-of- Pocket Maximums.

What is the HRA?

The CDHP Plan also has a Health Reimbursement Account (HRA) component. An HRA is a financial account that the Plan uses to allocate HRA dollars to reimburse you for "qualified" medical and prescription drug expenses paid by you as they occur. This allows the Plan, under the CDHP option, to offset your medical and prescription costs. Typically, the reimbursement payments go directly to the providers and you do not incur any out-of-pocket expenses while you have HRA dollars available.

The remainder of this SPD provides more details about the specific benefits and provisions of the CDHP benefit option, including the Health Reimbursement Account.

CDHP PLAN FEATURES AND HOW THE PLAN WORKS

The CDHP Plan benefit option consists of Network, Out-of-Network, Virtual Network and "Gap Exception" provisions, depending on your geographic location of residence and how you utilize the Plan to access your Benefits as described below. The HRA feature is set up for all CDHP participants regardless of which Network you access for care.

Network/Out-of-Network Benefits and Providers (for those residing in a Network area)

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

Important

UnitedHealthcare works to provide you with greater access to Network Providers. You will notice the UnitedHealthcare website listed throughout the SPD, myuhc.com which can be accessed by you to obtain benefit information, ***locate Network Providers (including Premium℠ Tier Providers and Freestanding Facilities)***, request ID Cards, and research health topics. Please access the website identified on the back of your ID card. Additional information on this website can be found in the *Resources to Help You Stay Healthy* section.

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choice to receive Network Benefits or Out-of-Network Benefits will affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply. **Note:** ***Lumen uses the Choice Plus network of providers.***

You can receive even higher benefits by accessing network ***Premium℠ Tier Providers*** ("Premium Providers") and certain network ***Freestanding Facilities***. These designations are found on the myuhc.com website. (Not available in all markets) See below for more details about these added provisions.

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

Network and Out-of-Network Benefits as a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply. You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a Out-of-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider. If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level.

You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the Out-of-Network provider about their billed charges before you receive care.

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

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

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from an Out-of-Network provider. Therefore, in most instances, your out-ofpocket expenses will be less if you use a Network provider. Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to Out-of-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to Glossary, of the SPD for details about how the Shared Savings Program applies.

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

Out-of-Network Benefits Exception (Gap Exception)

(not applicable to Retirees living in Virtual network areas)

You may be eligible to receive Benefits for certain Out-of-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a 30-mile radius of your home zip code. This is called a Gap Exception. **UnitedHealthcare must approve any Benefits payable under this exception before you receive care.** If approved, your eligible claims will be paid at 80% of billed charges.

Virtual Network Benefits

If you live outside of the CDHP Plan Network area ("out of area") the Plan will still pay Benefits for you and your covered dependents at Network levels. This "Virtual Network" is designed to help Retirees ***who live in rural areas with no access to Network providers***. You may be asked to pay the provider at the time of service and then submit a claim to the Plan for reimbursement.

After you have satisfied the required Network Deductible and Coinsurance, the Plan will pay Benefits at the Network level—you will be responsible for any remaining amount. Covered services will be subject to "Eligible Expenses" as described in the **"GLOSSARY MEDICAL"** section. You will **automatically** be enrolled in the Virtual Network if this is applicable (otherwise this is not available to you) and your ID will also include an "out of area" designation if this applies.

Network and Out-of-Network Providers/Facilities (for Virtual Network)

You have the freedom to choose the Physician, facility or health care professional you prefer each time you need to receive Covered Health Services.

The choice you make to receive these Network Benefits or Out-of-Network Benefits affect the amounts you pay.

Generally, when you receive Covered Health Services from a Network provider (including facilities), you pay less than you would if you receive the same care from an Out-of-Network provider. However, since you may not have direct access to the Network providers, your level of Benefits will be the same if you visit a Network provider or Out-of-Network provider. Because the total amount of Eligible Expenses may be less when you use a Network provider, the portion you pay will be less. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider. (Note: You may find some types of Network providers (including Premium Providers and Freestanding facilities) near you or you can travel further to seek care from a Network provider if you wish.)

Network Providers, including Premium Providers. The Claims Administrator (UHC) or its affiliates arrange for health care providers to participate in a Network. At your request, the Claims Administrator (UHC) will send you a directory of Network providers (including lactation counseling providers) free of charge. Keep in mind, *a providers Network status is subject to change*. To verify a providers status or request a provider directory, you can call The Claims Administrator (UHC) Customer Service phone number on the back of your ID card or log onto myuhc.com. You can also check directly with the Provider's office to see if they participate in the **Choice Plus** network.

Premium℠ Tier Providers and Freestanding Facilities

("Premium Providers") and Freestanding Facilities are designated by UnitedHealthcare from their Network Physicians and facilities as UnitedHealth Premium℠ Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth Premium℠ Program was designed to:

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

Note: *Premium Providers are only available for certain types of services such as: Family Practice, General Surgery, OB-GYN and Pediatrics and may not be available in some locations.*

Freestanding Facilities are network facilities which are used for outpatient, diagnostic or ambulatory centers or standalone laboratories which perform services and submit claims as an independent entity and not as a hospital.

How to Find a Premium Provider or a Freestanding Facility:

- Log into myuhc.com
- Select “Find a Doctor” to find doctors and facilities in your network by name, specialty, facility or condition. (**Note:** UnitedHealth Premium Tier 1 will be shown on the right side of the provider option.)
- Choose a facility marked ‘Freestanding Facility’ in the Additional Information section of the search results.
- You can also call the phone number on the back of your ID card for more details.

You will have a lower co-insurance (15% instead of 20% after meeting your annual deductible) when you use a Premium Provider or a Freestanding network facility instead of a hospital for outpatient services.

Note: Network providers are independent practitioners and are not Retirees of Lumen or the Claims Administrator (UHC).

Out-of-Network Provider. These Providers are not listed by UnitedHealthcare on myuhc.com. It is best to confirm with the Provider’s office before you receive services if they are in the UHC Choice Plus Network or a Out-of-Network provider. Provider network status is subject to change.

Possible Limitations on Provider Use. If the Claims Administrator (UHC) determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don’t make a selection within 31 days of the date you are notified, the Claims Administrator (UHC) will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the Out-of-Network level.

Eligible Expenses

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

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

- For Network Benefits for Covered Health Services provided by a Network provider, except for your cost sharing obligations, you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses.

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

Network Benefits

Eligible Expenses are based on the following:

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

Non-Network Benefits

When Covered Health Services are received from an non-Network provider, Eligible Expense are determined as follows: an amount negotiated by the Claims Administrator, a specific amount required by law (when required by law), or an amount the Claims Administrator has determined is typically accepted by a healthcare provider for the same or similar service. The Plan will not pay excessive charges. You are responsible for paying, directly to the non-Network provider, the applicable Coinsurance, Copayment or any deductible. Please contact the Claims Administrator if you are billed for amounts in excess of your applicable

Coinsurance, Copayment or any deductible to access the Advocacy Services as described below. Following the conclusion of the Advocacy Services described below, any responsibility to pay more than the Eligible Expense (which includes your Coinsurance, Copayment, and deductible) is yours.

Advocacy Services

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

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses. You must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

HRA dollars are allocated to your account to help you pay for your Deductible Expenses. The HRA dollars are used first before you pay any out-of-pocket towards the Deductible. Once you meet the Deductible the Plan pays Benefits at the Plan levels. See **YOUR HEALTH REIMBURSEMENT ACCOUNT (HRA)** for more details.

For those residing in the CDHP Network, there are separate Network and Out-of-Network Annual Deductibles for this Plan. Eligible Expenses charged by both Network and Out-of-Network providers apply towards both the Network individual and family Deductibles and the Out-of-Network individual and family Deductibles, accordingly.

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

Coinsurance

Coinsurance is the percentage of the Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible. Coinsurance amounts apply towards the Out-of-Pocket Maximum.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance. This also applies if you access a Premium Provider (or Freestanding Facility) where the Plan pays 85% after you meet the Annual Deductible; you are then responsible for paying the other 15% of your coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year. See **YOUR HEALTH REIMBURSEMENT ACCOUNT (HRA)** for more details.

There are separate Network and Out-of-Network Out-of-Pocket Maximums for this Plan. Eligible Expenses charged by both Network and Out-of-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the Out-of-Network individual and family Out-of-Pocket Maximums, accordingly.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in the **PRESCRIPTION DRUGS** section.

For those residing in the CDHP Network, the following table identifies what does and does not apply toward your Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of- Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Payments you make for services received toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Well Connected	No	No
Charges that exceed Eligible Expenses when applicable	No	No

For those residing in the CDHP Virtual Network, the following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Apply to the Out-of- Pocket Maximum?
Payments you make for Services received toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No
The amounts of any reductions in Benefits you incur by not notifying Well Connected	No
Charges that exceed Eligible Expenses, when applicable	No

See **COVERED CDHP (WITH HRA) BENEFITS** for specific dollar amounts for these provisions.

How the CDHP Works with an HRA

The Premium Consumer-Driven Health Plan starts with allocating an annual dollar amount for Retired Retirees and their Dependents into a Health Reimbursement Account (HRA) to help cover a portion of the Plan's Deductible. The combination of the HRA and the Member Responsibility is the Deductible, as shown in the **YOUR HEALTH REIMBURSEMENT ACCOUNT (HRA)** section.

Claims are first paid from the HRA before you are required to pay any out-of- pocket expenses. In order to satisfy the Deductible, you use a combination of the HRA and your own money. If you don't use the entire HRA amount, all remaining dollars can be rolled over to the next year*. And, if you spend your HRA dollars wisely, you minimize your out-of-pocket expenses.

If you meet the Deductible, then your claims for the remainder of the year are paid at 80% (adjusted for Premium providers or freestanding facilities, if applicable) for Network providers or 50% of Eligible Expenses

for Out-of-Network providers just like a traditional medical plan. Once you meet the Out-of-Pocket Maximum, the plan pays 100% of Covered Health Services for the remainder of the year.

***Note:** Any remaining eligible CDHP HRA dollars you have at the end of the year may be rolled over into the next year, even if you elect another CDHP or HDHP medical option. (Special provisions apply if you move to the HDHP Plan benefit option.)*

See **YOUR HEALTH REIMBURSEMENT ACCOUNT (HRA)** for more details.

YOUR HEALTH REIMBURSEMENT ACCOUNT (HRA)

Annual HRA Allocation

Through the PremiumCDHP Plan benefit option, the Company makes an annual allocation to a Health Reimbursement Account for you and your covered dependents. All contributions allocated to the account are owned and payable from the Company's general assets. The amount of the allocation will be determined each year by the Plan. You are not permitted to make any contribution to the HRA.

The annual Company allocation to your HRA is:

- $500 for Retiree only coverage
- $750 for Retiree + Spouse/Domestic Partner coverage
- $750 for Retiree + Child(ren) coverage
- $1,000 for Retiree & family coverage (Spouse/Domestic Partner and a Child(ren)

The HRA approach gives you the opportunity to build your available health care dollars over time. If you don't use the full amount of your HRA each plan year, any remaining amount can be **rolled over** and used the next plan year, provided you continue to be enrolled in a Lumen CDHP Plan benefit option as described below.

If you change medical plans during Annual Enrollment, what happens to your prior HRA funds?

Prior Year HRA Funds (aka) Carry-Over are available:

- Retirees who do not change medical plans and remain in the same plan – prior year funds are only available **after the current year HRA funds have been exhausted**. Once the current HRA funds are exhausted then, the carryover from prior years becomes accessible.
- If you change to the Doctors Plan from the CDHP, any remaining HRA funds from the prior years will be available after 90 days. The funds will be moved to a Spend Down HRA account and funds can be used for any patient responsibility. Claims will need to be manually submitted for reimbursement of these funds.
- If you change to the Surest Plan from the CDHP, any remaining HRA funds from the prior years will be available after 90 days. The funds will be moved to a Spend Down HRA account and funds can be used for any patient responsibility. Claims will need to be manually submitted for reimbursement of these funds.

As a reminder, retirees can view balances on myuhc.com. They can select "Previous Year" from the drop-down option to verify prior year's balances. As a norm, currently the portal will display "Current Year" by default.

*Based on limited extenuating, unforeseen circumstances, there may be opportunities where any remaining carry-over funds can be made available sooner, please contact **833-925-0487** or **317-671-8497** and listen for the prompts for Advocacy Services. Remember, if you decide to request your carry-over funds to be moved sooner, please ensure and confirm prior to calling that all your claims from the prior year have been submitted and processed.

What if you move from a CDHP to a HDHP with Optional Health Savings Account?

Note: Any CDHP HRA balance may also be rolled over if you change from a CDHP Plan benefit option to the HDHP Plan benefit option. After the run-out period, any rollover balances will be deposited into a post deductible HRA account. The balance would be available once you have met your HDHP deductible. See the

HDHP SPD for more information. (This roll over provision also applies if your coverage ends and you elect one of these Plan benefit options under COBRA or if you retire and elect one of these Plan benefit options under the Retiree and Inactive Health Plan.)

In addition, you must meet your HDHP deductible under the HDHP benefit provisions before you can access the CDHP HRA roll over dollars once they are transferred to your account. If you are changing enrollment to the HDHP Plan benefit option, see the HDHP SPD for more information on how to use the CDHP roll over dollars with the HDHP benefit option.

You can keep track of the funds in your HRA by going online to myuhc.com, by calling the toll-free number on the back of your ID card or by checking your monthly member statement sent to you by UnitedHealthcare.

Note: *HRA dollars can only be used when enrolled in one of the Lumen CDHP or HDHP Plan benefit options. If your participation in one of these Plan benefit options end for any reason (such as waiver of coverage or cancellation due to non-payment), any balance in your HRA will be forfeited to the Plan.*

Annual Member Responsibility

The annual Deductible is equal to your HRA allocation plus a specified out-of- pocket amount called, Member Responsibility.

Your Member Responsibility portion of the Deductible is:

- $1,000 for Retiree only coverage
- $1,500 for Retiree + Spouse/Domestic Partner coverage
- $1,500 for Retiree + Child(ren) coverage
- $2,000 for Retiree & family coverage (Spouse/Domestic Partner and a Child(ren)

Remember, the HRA dollars will be used first to pay your Deductible. If you have been in a CDHP benefit option for more than one year, you may have money saved up in your HRA from previous years. If so, you may have enough to cover your Member Responsibility – and therefore not pay anything out of your pocket before the Co-insurance begins.

Annual Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most that you will pay toward covered health expenses in a Plan year once you reach the Out-of-Pocket Maximum under the CDHP Plan, the Plan pays 100% of covered services for Network providers and 100% of Eligible Expenses for Out-of-Network providers for all covered family members.

Your Out-of-Pocket Maximum includes the Deductible (HRA + Member Responsibility).

The Network Out-of-Pocket Maximums are:

- $3,200 for Retiree only coverage
- $4,800 for Retiree + Spouse/Domestic Partner coverage
- $4,800 for Retiree + Child(ren) coverage
- $6,400 for family coverage (a Spouse/Domestic Partner and a Child(ren)

The out-of-network Out-of-Pocket maximums are:

- $6,400 for Retiree only coverage
- $9,600 for Retiree + Spouse/Domestic Partner coverage
- $9,600 for Retiree + Child(ren) coverage

- $12,800 for family coverage (a Spouse/Domestic Partner and a Child(ren)

Therefore, the HRA pays the first part of the Deductible, then you pay the Member Responsibility portion, then the Coinsurance pays like a traditional health care plan. Once your out-of-pocket expenses (a combination of the HRA amount, your Member Responsibility amount and any Coinsurance amounts you have paid) reach the Out-of-Pocket Maximum limit—the plan pays 100% of covered expenses for the remainder of the Plan year.

HRA Dollars and Deductible for Mid-Year Enrollments/Changes

If you retire during the calendar year and enroll in the CDHP, a prorated amount will be allocated to your HRA. In addition, the Member Responsibility will be pro-rated. The schedule is as follows:

Hire Date	HRA Allocation	Member Responsibility
January 1 to March 31	100%	100%
April 1 to June 30	75%	75%
July 1 to September 30	50%	50%
October 1 to December 31	25%	25%

For example, if you retire on May 10th and elect “Retiree only” CDHP coverage, you will receive a retiree HRA allocation of 600 ($800 x 75%).

If you were already enrolled in one of the active CDHP benefit options before retirement, your current HRA balance will roll over if you elect to remain in one of the CHDP Plan benefit options.

HRA – Qualifying Life Events

Mid-Year Policy Changes are allowed when there is a Qualifying Life Event (Employment Transfer, Promotion etc.). When this occurs, the expectation is for any Deductible, Out-Of-Pocket Maximum (OOPM) and HRA (Accumulators) that have been met will be transferred from one policy to another.

- CDHP plans only – When a family coverage level changes (i.e. Retiree, Retiree +spouse/domestic partner, Retiree +children, Retiree +family), the member/s that remain covered under the group plan keep their accumulated Deductible, OOPM and HRA accumulators from when they had the prior coverage level. The previous Deductible, OOPM and remaining HRA (if applicable) balances will be updated to reflect the adjusted amounts. Please remember the process can take up to 30-45 days to move applicable accumulators and HRA funding.
- If you retire and enroll as a dependent under your spouse’s plan and have any remaining HRA balance you can have the balance moved under the spouse plan after the run-out period of 90-days if you contact the Lumen Health and Life Service Center at **833-925-0487** or **317-671-8497** (International callers) or **800-729-7526**, option 2 and option 1 and listen for the prompts for Advocacy Services.
- If you retire and suspend coverage under the Plan and then re-enroll in the Plan at a later date and remain eligible for coverage, any previous remaining HRA funds will be reinstated under the Plan.

Exception: If there is a break in coverage for a member moving from one plan to another, the Deductible, OOPM and HRA (accumulators) balances will not transfer.

Note: If you have a qualifying event that makes you eligible to change plans during the year, you will need to notify UHC by calling the number on the back of your medical ID card that you are changing plans and would like to have the accumulators and remaining HRA funds moved to your new plan. HRA funds will be deposited into Post Deductible HRA account.

Moving to HDHP

If you were enrolled in a CDHP medical option and change your medical option during Annual Enrollment to elect the HDHP, any remaining CDHP HRA funds will be automatically moved to a Post-Deductible HRA after a 90-day claims run- out period.

A post deductible HRA is an HRA that reimburses claims once the annual deductible has been met for the plan year. IRS regulations prevent members enrolled in a Health Savings Account (HSA) to have other first dollar coverage, such as through an HRA.

Please note with your Post Deductible HRA, any unused HRA funds are only eligible for medical and pharmacy coinsurance expenses after you have met the annual In-Network deductible. Clams will automatically roll over to your Post Deductible HRA, so members will not have a choice on where or how to use the funds. Therefore, members may not turn off auto-submission with post deductible HRA.

HOW TO ACCESS YOUR HRA DOLLARS

Health Care Spending Card (HCSC)

United Healthcare will provide a Health Care Spending Card Debit MasterCard® ("HCSC"), to any retired Employee that enrolls in the CDHP. The HCSC is a special purpose debit card (works like a credit card) that is used to pay for Eligible Expenses directly from your HRA and eliminates the need for you to submit most paper claims. Eligible Expenses include such things as pharmacy prescriptions. You may also use the card to pay for Coinsurance amounts when using UnitedHealthcare Network providers. **However, you shouldn't pay for these expenses until your claim has been processed by UHC and you know your patient responsibility amount.** The HCSC can only be used to pay for Eligible Expenses when HRA (or FSA*) dollars are available. Therefore, the card cannot be used once your HRA (and/or FSA) balance(s) has been exhausted.

Each family will receive two cards. The HCSC has 4-year expiration and should not be discarded between plan years. If you lose or misplace your HCSC or have questions about the use of your HCSC, contact HCSC Customer Service at **866-755-2648**.

The use of the card is voluntary. However, if you are going to use it, you will need to activate your HCSC as soon as you receive it. Once your card has been activated, you must wait one full business day before you use your card (i.e., if you activate your card on a Monday, you will need to wait until Wednesday to use the card). If you decide not to activate the HCSC simply destroy and discard both cards. However, using the card is the only way to pay for prescription drugs directly from your HRA.

Without the card, you can still be reimbursed for HRA Eligible Expenses by completing a paper reimbursement form or by using the automatic reimbursement (auto-submission) feature. See **HRA CLAIM PROCEDURES** and **FILING A MANUAL HRA CLAIM** for more information on these two processes.

If you elect the HDHP and you have remaining funds in your HRA during Annual Enrollment, the HRA funds will be automatically moved after 90 day run-out into a Post Deductible HRA plan which will be tied to your HDHP.

Using the Health Care Spending Card

In order to use the Health Care Spending Card Debit MasterCard®, or HCSC, you will need to enter **credit** on the Point-of-Service (POS) bankcard terminal just as if you were purchasing an item using a credit card. No Personal Identification Number PIN is required when you use the HCSC. Each time the card is used for payment, you will sign a receipt. Your FSA card is regulated by the IRS; therefore, you should retain all itemized receipts generated from the HCSC. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the HCSC through the POS bankcard terminal, your available Benefit balance is verified. The card validates your purchases real-time and automatically debits your HRA account based on the guidelines established by the IRS and your specific plan design. A claim number is assigned to the transaction.

Qualified Locations and Providers

The HCSC may not be used at point of sale to make a purchase from non-participating merchants. You will need to pay using another form of payment, and then submit eligible expense receipts for reimbursement as described under the **FILING A MANUAL HRA CLAIM** section.

The HCSC may be used for a point of sale purchase at any UnitedHealthcare Network provider or participating merchant with a POS bankcard terminal that accepts MasterCard® such as a Network hospital, Network physician and retail Network pharmacy counters.

You may choose to use your HCSC for mail order prescription or for out-of-country by going to an online pharmacy at myuhc.com. Additionally, your HCSC can be used at Walgreens retail stores or at participating drug store and pharmacy merchants.

Partial authorization capability allows you to use your HCSC with transactions amounts greater than the funds available in your HRA for a portion of the transaction at merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HRA, the HRA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment. ***Note:*** *not all merchants accept partial authorization.*

Substantiation

The IRS has clarified substantiation requirements for debit card transactions and has approved the Inventory Information Approval System (IIAS) as a method for retailers to identify and substantiate Eligible Expenses. The Inventory Information Approval System (IIAS) enables participants to purchase Eligible Expenses from a broad range of retailers increasing the use of the card and reducing manual claims processing requirements. A retailer's point of sale system identifies eligible HRA/healthcare FSA purchases by comparing the inventory control information (UPC or SKU number) against the list of restricted eligible medical expenses as described in IRS Section 213(d).

The IRS states merchants need to be able to identify IRS Section 213(d) eligible items, however, it is not required that merchants break out the eligible items by Prescription and General Healthcare (OTC). While most merchants will break this out, there are some that do not. To determine if a merchant separates prescription, look for a "check mark" in the Supporting Prescription Subtotal column of the Merchant List found on sig-is.org.

Members can visit sig-is.org and select the IIAS Merchants List to view a list of participating merchants. The Merchant List is updated every two days. You may use your HCSC at participating merchants based on the benefit Plans you are enrolled in:

- FSA only – you must use merchants that are certified and have a status of "Live" in the Planned Merchant Implementation Date column.
- HRA only or HRA with FSA – you must use merchants that are certified, have a status of "Live" and a "check mark" in the Supporting Prescription Subtotal column.

The HCSC can only be used to pay for eligible expenses that are equal to or less than the dollar amount remaining on the HCSC. For example, if you have $200 remaining in your health care FSA but are trying to purchase a prescription for $250 with the HCSC, the card will decline because the amount of the prescription is more than the amount available on the HCSC. You will need to pay for the expense out-of-pocket and submit a claim to United Healthcare to receive reimbursement.

The Internal Revenue Service may require that you provide a receipt, statement or Explanation of Benefits for certain HRA Eligible Expenses that have already been reimbursed through your card in order to prove that the services received were for qualified medical expenses incurred within the plan year, as defined by the Plan. You will be notified through a letter if you need to provide such information. If UnitedHealthcare does not receive the required documents as described in the letter, your card will be deactivated in accordance with applicable IRS regulations and guidelines. If UnitedHealthcare determines that the claim was not for a qualified medical expense as described

in the letter this will be considered an overpayment to you and UnitedHealthcare will automatically withhold the payment of future claims until the full amount of the overpayment is received. If your card is deactivated due to the payment of an ineligible expense or the lack of documentation as described in your letter, we will activate your card upon receiving the requested documentation or the payment in full of any outstanding overpayment(s).

Member Health Statements and HRA Yearly Statements

Member Health Statements are available on the consumer website, myuhc.com. A member health statement is produced whenever there is claims activity for a member. You will receive monthly health statements and a HRA yearly statement which will include your card activity. If you note a discrepancy with a card transaction, call the number on the back of your HCSC to resolve the issue.

HRA CLAIM PROCEDURES

Auto HRA Claims Submission

The HRA has been designed to allow certain claims to be automatically submitted to your account for reimbursement. UnitedHealthcare will coordinate payments from your HRA for medical claims and prescription drug claims. You can turn this feature “off” or back “on” via myuhc.com.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will automatically process the payment for the medical Plan’s portion of the cost of the Covered Health Services and send it directly to the Physician or facility. If you have not met your Deductible, the cost of the service is based on the total amount of the bill, as the traditional Coinsurance component of the Plan has not been reached yet. Therefore, you should wait until UHC has determined if there are HRA funds available, then FSA funds (if applicable), then your Member Responsibility amount, if any.

When auto-submission is elected all reimbursements from the HRA will be sent directly to the provider, exceptions are listed below. When no provider information is available the reimbursement will be sent to you. In the 4 exception situations listed below, the reimbursement from the HRA will go directly to you and not the provider:

- Prescription drug claims
- Manually submitted claims (paper claims you submit directly)
- Out-of-Network provider claims
- Claims adjustments

Manual HRA Claim Submission

There are some types of claims that will not be processed automatically for which you will need to submit a claim. When the Auto-rollover feature does not apply, you must submit a claim for reimbursement from your HRA (or FSA) including any other types of expenses other than Covered Health Services and any health expenses not submitted to UnitedHealthcare, such as those listed above.

Out-of-Network Benefits

If you receive a bill for Covered Health Services from an Out-of-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing.

To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card

If you receive Covered Health Services from an Out-of-Network provider, funds from your HRA (and/or FSA) will automatically be reimbursed to you, up to the amount available in your HRA (and/or FSA). You will only be reimbursed from your HRA (or FSA) for expenses incurred while you are a Covered Person under the Plan. You are responsible for paying the provider in this situation.

Out-of-Network Prescription Drug Benefit HRA Claims

When you visit a pharmacy or order your medications through mail order on the Internet at myuhc.com, you are responsible for paying any amounts due to the pharmacy at the time you receive your prescription drugs.

Important – Timely Filing of Out-of-Network Claims

All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated.

Note: You cannot be reimbursed for any expense paid under your medical plan, and any expenses for which you are reimbursed from your HRA cannot be included as a deduction or credit on your federal income tax return.

FILING A MANUAL HRA CLAIM

Request for Withdrawal Form

To be reimbursed from your available HRA funds simply submit a reimbursement form, called a Request for Withdrawal Form, for the HRA Eligible Expenses that have been incurred. A Request for Withdrawal Form is available on the Internet at myuhc.com. For reimbursement from your HRA, you must include proof of the expenses incurred as indicated on the Request for Withdrawal Form. For HRA Eligible Expenses, proof can include a bill, invoice, or an Explanation of Benefits (EOB) from your group medical plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-ofpocket expenses were after payments under other group medical plans. (See the FSA SPD for this information as it relates to the FSA.)

To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare HRA Claims submittal address:

Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506

Important

You can view EOB's and Health Statements online via myuhc.com. myuhc.com includes many features such as the option to:

- View your HRA summary page detailing contributions and remaining balance left in your HRA;
- View your HRA Claims Summary including claim transaction details.

Health Statements

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

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

Explanation of Benefits (EOB)

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

Important Note

- The date on which you incurred a service is used when deducting amounts from your HRA.

See **CLAIMS PROCEDURES** for information on denied claims.

WELL CONNECTED (CASE MANAGEMENT)

The Claims Administrator (UHC) provides a program called Well Connected designed to deliver comprehensive, personalized services and efficient care for you and your covered Dependents. Certain services require that you obtain **Prior Authorization** through Well Connected **before** receiving services.

When you seek Prior Authorization as required for certain services, the Claims Administrator (UHC) and Well Connected Advocates, Nurses and coaches will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, patient advocacy and closing any gaps in your care.

The goal of the program and obtaining the Prior Authorization is to ensure you receive the most appropriate and cost-effective health and wellness services available. *A **Personal Health Support Nurse** is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.*

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

The Well Connected Personal Health Support Nurse will provide a comprehensive set of services to help you and your covered family members receive appropriate medical care. The Well Connected Program components are subject to change without notice. As of the publication of this SPD, the Well Connected program includes:

Personal Health Support Nurse Services

- **Admission Counseling** – For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient Care Management** – If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physicians treatment plan is being carried out effectively.
- **Readmission Management** – This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from Well Connected to confirm that medications, needed equipment, or follow-up services are in place. Well Connected will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** – Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Well Connected Nurse to discuss and share important health care information related to the participants specific chronic or complex condition.
- **Clinical Services and Disease Management:**
  - Asthma, COPD, Coronary Artery Disease, Congestive Heart Failure, and Diabetes
  - Cancer and other complex medical conditions
  - Neonatal Services
- **Wellness Coaching to provide you the tools you need to:**
  - Eat well
  - Improve heart health
  - Live healthier with diabetes
  - Lose weight
  - Manage stress
  - Meditate
  - Sleep better
  - Start a fitness plan
  - Work on financial wellbeing

If you do not receive a call from a Well Connected Personal Health Support Nurse but feel you could benefit from any of these programs, please call 800-842-1219 the phone number on the back of your ID card.

Prior Authorization (Requirements for Notifying Well Connected) Network providers are generally responsible for obtaining Prior Authorization from Well Connected **before** they provide certain services to you.

However, when you choose to receive certain Covered Health Services from Out-of-Network providers, **you are responsible for obtaining Prior Authorization from Well Connected before you receive these Covered Health Services.** In many cases, your Out-of-Network Benefits will be reduced if Prior Authorization from Well Connected is not obtained.

Quit for Life Program

The Quit for Life Program is based on 30 years of research and clinical experience and has helped thousands of people take control of their lives and their health by quitting tobacco, vaping and other alternative nicotine delivery systems. With help from a Quit Coach®, you will create a quit plan that is right for you to address previous barriers, develop new skills and learn to manage triggers in situations where you normally use tobacco and nicotine products.

When you enroll in the program you will receive:

- Unlimited 24/7 access to Quit Coaches
- Free nicotine replacement therapy (patch or gum) mailed directly to your home, if appropriate
- Decision support for prescription medications, if appropriate
- Online Group coaching sessions to create a sense of community and facilitate peer learning
- Access to a proprietary, interactive website and mobile app which offers online support tools that complement your coaching sessions and enable further exploration
- Email and text messaging that provides personalized messages, urge management support as well as planning and motivational support

For additional details about the Quit For Life Program call **866-784-8454** or go online at quitnow.net/lumen

Prior Authorization is required from Well Connected for the following services:

- Ambulance Services that are non-emergent ground and air;
- breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature;
- Clinical Trials;
- Congenital Heart Disease services;
- Durable Medical Equipment and Prosthetic Devices for items that will cost more than $1,000 to purchase or rent (including Diabetic supplies);
- All Genetic testing including breast cancer (BRCA);
- Growth Hormone
- home health care;
- hospice care – inpatient;
- Hospital Inpatient Stay, including Emergency admission;
- Lab, X-ray and major diagnostics – CT, PET scans, MRI, MRA and Nuclear Medicine;
- maternity care that exceeds the delivery timeframes as described in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section;
- Mental Health Services – inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 – 50 minutes in duration, with or without medication management;
- Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders (including ABA Therapy) -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 – 50 minutes in duration, with or without medication management;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Sleep studies (Lab, X-Ray and Diagnostics – Outpatient);
- Surgery – only for the following outpatient surgeries: diagnostic catheterization and electrophysiology implant and sleep apnea surgeries;
- Surgery – cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgeries;
- Substance Use Disorder Services – inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 – 50 minutes in duration, with or without medication management; and
- Therapeutics – only for the following services: dialysis, intensity modulated radiation therapy, and MR-guided focused ultrasound;
- Transplantation services.

When you choose to receive services from Out-of-Network providers, UnitedHealthcare urges you to confirm with Well Connected that the services you plan to receive are Covered Health Services. Thats because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are **excluded**. In other instances, the same procedure may meet the definition of Covered Health Services. By calling **before** you receive treatment, you can check to see if the service is subject to Prior Authorization, limitations or exclusions such as:

- the cosmetic procedures exclusion. Examples of procedures that may or may not be considered cosmetic include: breast reduction and reconstruction (except for after cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty;
- the experimental, investigational or unproven services exclusion; or
- any other limitation or exclusion of the Plan.

For Prior Authorization timeframes and reductions in Benefits that apply if you do not contact Well Connected, see **ADDITIONAL BENEFIT COVERAGE DETAILS**.

Contacting Well Connected is easy.

Simply call the toll-free Customer Service number on your ID card.

COVERED CDHP (WITH HRA) BENEFITS

Plan Highlights (CDHP Network and Virtual Networks)

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

Plan Features	CDHP Network (and Virtual Network)	Out-of-Network
Annual Deductible[1]		
• Retiree (**$1,000 includes a $500 HRA allocation**)	$1,500	$3,000
• Retiree + Spouse/ Retiree + Child/ren (**$1,500 includes $750 HRA allocation**)	$2,250	$4,500
• Family – cumulative Annual Deductible[2] (**$2,000 includes $1,000 HRA allocation**)	$3,000	$6,000
Annual Out-of-Pocket Maximum[1] (*includes the Deductible*)		
• Retiree	$3,200	$6,400
• Retiree + Spouse/ Retiree + Child/ren	$4,800	$9,600
• Family – cumulative Out-of- Pocket Maximum[3]	$6,400	$12,800
Lifetime Maximum Benefit[4]	Unlimited	

[1]The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

[2]The Plan does not require that you or a covered Dependent meet the single Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the single coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.

[3]The Plan does not require that you or a covered Dependent meet the single Out-of- Pocket Maximum in order to satisfy the Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the single coverage Out-of-Pocket Maximum stated in the table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

[4] There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally, the following are considered to be Essential Benefits under the Patient

Protection and Affordable Care Act: **Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.**

Covered Benefits Summary Table

This table provides an **overview** of the Plans coverage levels and is not intended to be a complete listing. For additional detailed descriptions of your Benefits, refer to **ADDITIONAL BENEFIT COVERAGE DETAILS** section after this Table.

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Eligible Expenses.

Covered Health Services[1]	**Percentage of "Eligible Expenses" Payable by the Plan:**	
	CDHP Network (and Virtual Network*) (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)	**CDHP Out-of-Network*** (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)
Abortion See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Acupuncture Services Up to 20 treatments per calendar year (combined INN & OON)	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Ambulance Services - Emergency Only (Ground or Air) ***Requires Prior Authorization if non-emergency*** Ground or Air Ambulance, as UnitedHealthcare determines appropriate.	100% after you meet the Annual Deductible	100% after you meet the Network Annual Deductible
Cancer Resource Services Program (CRS) ***Requires Prior Authorization*** See **ADDITIONAL BENEFIT COVERAGE DETAILS**.	80% after you meet the Annual Deductible	Not Covered
Chiropractic Care See **Spinal Treatment**		
Congenital Heart Disease (CHD) Surgeries • Hospital – Inpatient Stay ***Requires Prior Authorization***	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Dental Services – Accident Only	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Diabetes Services • Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care • Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section. Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under Durable Medical Equipment in this section and in the **"PRESCRIPTION DRUGS"** section. With the exception of insulin pumps, if ordered by a prescriber. Children under the age of 18 can elect a pump that best fits their lifestyle and needs.	

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	CDHP Network (and Virtual Network*) (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)	**CDHP Out-of-Network*** (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)
Dialysis *Requires Prior Authorization* See **ADDITIONAL BENEFIT COVERAGE DETAILS** for limits.	80% after you meet the Annual Deductible	Not Covered
Durable Medical Equipment (DME) *Requires Prior Authorization for some items* Up to $350 per calendar year for foot orthotics. See Orthotics section of this Table below. See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Emergency Health Services If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Coinsurance and/or deductible. The Benefits for an Inpatient Stay in a Hospital will apply instead. This does not apply to services provided to stabilize an Emergency after admission to a Hospital.	80% after you meet the Annual Deductible	
Enteral Nutrition See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Gender Identity Dysphoria *Requires Prior Authorization* See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section for limits.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hearing Care • Hearing Aids are covered up to a $1,000 every three calendar years per hearing impaired ear (combined for Network and Out-of-Network) • Non-routine hearing aid exam (limited to $100 per calendar year) (includes Surgery for cochlear implants)	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Home Health Care *Requires Prior Authorization* Up to 120 visits per calendar year (combined INN & OON)	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospice Care *Requires Prior Authorization*	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Hospital – Inpatient Stay *Requires Prior Authorization* **2nd.MD** $500 additional responsibility will apply to hip, knee, shoulder, and spine surgeries if a 2nd MD consult is not completed.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Infertility Services • Physician's Office Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	CDHP Network (and Virtual Network*) (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)	**CDHP Out-of-Network*** (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)
• Outpatient services received at a Hospital or Alternate Facility Benefits for infertility services are limited to $10,000 per Covered Person combined INN & OON RX maximum during the entire period you are covered under the plan. (***Note:*** *These benefits do not apply to surrogacy services. See the* **EXCLUSIONS: PLAN BENEFITS NOT COVERED** *section for more details.*)	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Injections in a Physician's Office See **"Preventive Care Services"** for more information.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient *Requires Prior Authorization if related to Sleep Studies*	80% after you meet the Annual Deductible	50% after you meet the Network Annual Deductible
Lab, X-Ray and Major Diagnostics (such as CT, PET, MRI, MRA, Nuclear Medicine, cardiology tests, etc.) – Outpatient *Requires Prior Authorization*	80% after you meet the Annual Deductible	50% after you meet the Network Annual Deductible
Mental Health Services • Hospital – Inpatient Stay *Requires Prior Authorization* • Physician's Office Services	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	50% after you meet the Annual Deductible 50% after you meet the Annual Deductible
Naturopathic Professional Services Up to 20 visits per Covered Person per calendar year for Network and Out-of-Network Benefits combined.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders • Hospital – Inpatient Stay *Requires Prior Authorization* • Including ABA Therapy Services Physician's Office Services	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	50% after you meet the Annual Deductible 50% after you meet the Annual Deductible
Nutritional Counseling	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Obesity Surgery • Physician's Office Services • Physician Fees for Surgical and Medical Services • Hospital – Inpatient Stay **Lab and x-ray** See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	Not Covered Not Covered Not Covered Not Covered
Orthotics Up to a $350 per Covered Person per calendar for foot orthotics for Network and Out-of-Network Benefits combined	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	CDHP Network (and Virtual Network*) (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)	**CDHP Out-of-Network*** (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)
Ostomy Supplies	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Covered Health Services provided by a Out-of-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Out-of-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services. Eligible Expenses will be determined as described in *How the Plan Works*, under **Eligible Expenses**.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Physician's Office Services – Sickness and Injury • Non-routine hearing aid exam (limited to $100 per calendar year) • Lab, X-Ray and Diagnostics	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	50% after you meet the Annual Deductible 50% after you meet the Annual Deductible
Pregnancy – Maternity Services • Physician's Office Services • Hospital – Inpatient Stay • Physician Fees for Surgical and Medical Services **Note: Dependent Children (of any age) are not covered for any maternity Benefits including complications resulting from pregnancy. Please see additional benefit coverage details under Pregnancy for more details** See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section for more details and information regarding the Healthy pregnancy Program and the Neonatal Resource Services (NRS).	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	50% after you meet the Annual Deductible 50% after you meet the Annual Deductible 50% after you meet the Annual Deductible
Preventive Care Services • Physician Office Services • Lab, X-ray or Other Preventive Tests (includes MRI's performed for women who cannot have mammograms due to a mastectomy) (first screening each calendar year is considered as preventive). Also includes Cologuard® colorectal cancer screening test once every 3 years for members age 50 and older • Breast Pumps • Immunizations – (Injections include the Shingles injections/ shot received by a Network Provider and by a Network Pharmacy. However, immunizations for personal travel are not covered.)	100% 100% 100% 100%	Not Covered Not Covered Not Covered Not Covered

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	CDHP Network (and Virtual Network*) (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)	**CDHP Out-of-Network*** (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)
• Lactation counselors • BRCA testing See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section for more information	100% 100%	100% 100%
Private Duty Nursing – Outpatient	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Reconstructive Procedures • Physician's Office Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
• Hospital – Inpatient Stay ***Requires Prior Authorization***	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
• Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
• Prosthetic Devices	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
• Surgery – Outpatient ***Requires Prior Authorization***	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Rehabilitation Services – Outpatient Therapy Any combination of manipulative Treatment and physical therapy for new low back pain: 100% for the first 3 visits in a year with an in-network provider	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Scopic Procedures – Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Second Surgical Opinion See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section for more limits	100%	100%
2nd.MD $500 additional responsibility will apply to hip, knee, shoulder, and spine surgeries if a 2nd MD consult is not completed. See **ADDITIONAL BENEFIT COVERAGE DETAILS** for more information.	100%	100%
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services *Requires Prior Authorization* Up to 120 days per Covered Person per calendar year for Network and Out-of-Network Benefits combined	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Spinal Treatment Up to 20 visits per calendar year (combined INN & OON services) Any combination of Manipulative Treatment and physical therapy for new low back pain: 100% for the first 3 visits in a year with an in-network provider See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	CDHP Network (and Virtual Network*) (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)	**CDHP Out-of-Network*** (*subject to Eligible Expenses--see **GLOSSARY MEDICAL**)
Substance Use Disorder Services • Hospital – Inpatient Stay • Physician's Office Services	 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	 50% after you meet the Annual Deductible 50% after you meet the Annual Deductible
Surgery – Outpatient *Requires Prior Authorization for certain services* **2nd.MD** $500 additional responsibility will apply to hip, knee, shoulder, and spine surgeries if a 2nd MD consult is not completed.	80% after you meet the Annual Deductible	Not Covered
Temporomandibular Joint Dysfunction (TMJ)	Depending upon where the Covered Health Services is provided, Benefits for temporomandibular joint (TMJ) services will be the same as those stated under each Covered Health Services category in this section.	
Therapeutic Treatments – Outpatient *Requires Prior Authorization for certain treatments*	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Transplantation Services *Requires Prior Authorization* See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section.	
Travel and Lodging (If services rendered by a Designated Facility) See the **ADDITIONAL BENEFIT COVERAGE DETAILS** section for more information	For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures	
Urgent Care Center Services	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible
Wigs For members with a Cancer or Alopecia diagnosis. One wig per lifetime.	80% after you meet the Annual Deductible	50% after you meet the Annual Deductible

You must obtain prior authorization through Well Connected, as described in the **"WELL CONNECTED RESOURCES TO HELP YOU STAY HEALTHY"** section to receive full Benefits before receiving certain Covered Health Services from an Out-of-Network provider. In general, if you visit a Network provider, that provider is responsible for contacting Well Connected **before** you receive certain Covered Health Services. See **"ADDITIONAL BENEFIT COVERAGE DETAILS"** for further information.

Multiple Surgical Procedure Reduction Policy

When you have multiple procedures performed at the same time, the Plan will pay:

- 100% of your coinsurance amount for the primary or major surgical procedure;
- 50% of your coinsurance amount for the secondary procedure; and third procedure

Special rules for multiple endoscopic procedures may apply if multiple procedures are performed using the same scope. Secondary and subsequent procedures using the same scope are reduced based on a different percentage determined by the value of doing the diagnostic scope with no surgery.

Agent for Service of Legal Process: General Counsel

100 CenturyLink Drive
Monroe, LA 71203

Legal process may also be served on:

CT Corporation System (a.k.a. CT Corporation)
1675 Broadway, Suite 1200
Denver, Colorado 80202

ADDITIONAL BENEFIT COVERAGE DETAILS

This section supplements the Covered Benefit Summary Table above for the CDHP Plan Benefits.

While the table above provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits and associated specialty Programs.

These descriptions also include any additional limitations that may apply, as well as Covered Health Services for which you must call Well Connected to obtain prior authorization.

The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in the **EXCLUSIONS: PLAN BENEFITS NOT COVERED** section which is subject to change from time to time and over time.

ABA Therapy

Refer to **Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders**

Abortion

Benefits are available for Elective and Non-Elective Abortions and are covered under the surgical benefit.

Acupuncture Services

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

- Acupuncturist;
- Chiropractor;
- Doctor of Medicine;
- Doctor of Osteopathy;

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

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

Any combination of Network Benefits and Out-of-Network Benefits is limited to 20 treatments per Covered Person per calendar year.

Ambulance Services – Emergency/Non-Emergency Only

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital that offers Emergency Health Services. See **GLOSSARY MEDICAL** for the definition of Emergency.

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

Coverage includes non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance as UnitedHealthcare determines to be appropriate) between facilities when the transport is any of the following:

1. From an Out-of-Network Hospital to a Network Hospital;
2. To the closest Network Hospital or facility that provides Covered Health Services that were not available at the original Hospital or facility;
3. From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility.

Prior Authorization is required for non-emergency Ambulance service.

Cancer Resource Services (CRS)

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

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

- be referred to CRS by a Well Connected Nurse;
- call Member Services at the phone number on the back of your ID card; or
- visit myoptumhealthcomplexmedical.com

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

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

Cancer clinical trials and related treatment and services are covered by the Plan. Such treatment and services must be recommended and provided by a Physician in a cancer center. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given.

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

To receive Benefits under the CRS program, **you must obtain Prior Authorization from** Well Connected **PRIOR** to obtaining Covered Health Services. The Plan will only **pay Benefits** under the CRS program **if** Well Connected provides the proper Prior Authorization to the Designated Facility provider performing the services **(even if you self-refer to a provider in that Network).** ***Call the phone number on the back of your ID card.***

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physicians office.

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

Pre-Service Notification Requirement Please remember for Out-of-Network benefits, **you must obtain Prior Authorization** from Well Connected as soon as possible (ASAP) for Cellular or Gene therapy. **If Prior Authorization is not obtained from Well Connected, Benefits for Covered Health Services will be subject to a $150 reduction.** *Call the phone number on the back of your medical ID card.*

Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

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

Routine costs for clinical trials do not include:

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

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

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

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

Prior Authorization is required for Clinical Trials.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Well Connected **as soon as the possible (ASAP)** of participation in a clinical trial arises. **If Prior Authorization is not obtained ASAP, Benefits will be responsible for paying all charges and no Benefits will be paid.** ***Call the phone number on the back of your ID card.***

Congenital Heart Disease (CHD) Surgeries

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

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

CHD services other than those already listed are **excluded** from coverage, unless determined by a Designated Facility or Well Connected to be proven procedures for the involved diagnoses. To contact Well Connected about CHD services, please refer to the Member Services phone number on the back of your ID card.

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

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

Prior Authorization is required for Congenital Heart Disease services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization from** Well Connected **as soon as CHD is suspected or diagnosed. If Prior Authorization is not obtained from Well Connected as stated above, Benefits for Covered Health Services will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

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

Dental Services – Accident Only

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

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident.

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

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

The Plan also covers Dental sedation and general anesthesia when determined by Physician to be medically necessary.

Before the Plan will cover treatment of an injured tooth, the dentist must certify that the tooth is virgin or unrestored, and that it:

- has no decay;
- has no filling on more than two surfaces;
- has no gum disease associated with bone loss;
- has no root canal therapy;
- is not a dental implant; and
- functions normally in chewing and speech.

Dental services for final treatment to repair the damage caused by accidental injury must be started within three months of the accident, or if not a covered participant at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a covered participant at the time of the accident, within the first 12 months of coverage under the Plan

Please remember that **you should notify** Well Connected **as soon as possible (ASAP)**, but ***at least five business days BEFORE*** follow-up (post- Emergency) treatment begins. You do **not** have to provide Prior Authorization before the initial Emergency treatment. When **you request Prior Authorization in advance**, Well Connected can determine whether the service is a Covered Health Service. ***Call the phone number on the back of your ID card.***

Diabetes Services

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

Covered Diabetes Services	
Diabetes Self- Management and Training/Diabetic Eye Examinations/ Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self- Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. Children under the age of 18 can elect a pump that best fits their lifestyle and needs. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment in this section, unless ordered by a prescriber. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in the **PRESCRIPTION DRUGS** section. Benefits for diabetes self-management items will be the same as those stated under Durable Medical Equipment with the exception of insulin pumps, if ordered by prescriber. Children under the age of 18 can elect a pump that best fits their lifestyle and needs.

Prior Authorization is required for Diabetic items in excess of $1,000.

Please remember, for Out-of-Network Benefits, **you must obtain Prior Authorization** from Well Connected **BEFORE** obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item **exceeds**

$1,000. You must purchase or rent the DME from the vendor Well Connected identifies**. If Prior Authorization is not obtained in advance, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

DayTwo

DayTwo (Diabetes Program) is a science backed health program that empowers people by providing food as medicine approach to manage glucose levels and improve overall health. Research shows that people process the same foods differently which is why DayTwo analyzes the gut microbiome to provide personalized nutrition recommendations for you, and you alone. DayTwo's science has been shown to:

- Reduce A1C and medicines
- Balance blood sugar levels
- Improve energy, sleep and hunger

Benefits to you:

- A personal DayTwo registered dietician focused on you and your health
- An app that shows you what foods work best for your body
- The chance to improve health
- The best part is you CAN eat a variety of foods and understand how foods in different combinations make major differences in your blood sugar and how you feel.

Dialysis – Outpatient

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

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

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

Benefits under this section include:

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

Durable Medical Equipment (DME)

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

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable, with the exception of insulin pumps, if ordered by prescriber;
- supplies, including those that are disposable, for members under the age of 18 when there is a clinical need and is ordered by a prescriber;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

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

Examples of DME include but are not limited to:

- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are also excluded from coverage;
- burn garments;
- delivery pumps for tube feedings;
- equipment for the treatment of chronic or acute respiratory failure or conditions.

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- insulin pumps and all related necessary supplies as described under Diabetes Services in this section, with the exception of insulin pumps, if ordered by a prescriber
- Equipment for the treatment of chronic or acute respiratory failure or conditions

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

The Plan also covers foot orthotics up to $350 per calendar year. This dollar limit applies to Network Benefits and Out-of-Network Benefits combined. This Benefit is paid at 80% after you meet the Annual Deductible, ***even if provided in a physician's office.***

Compression stockings are a covered benefit when they are used in combination with a UHC approved pneumatic compression device in the treatment of Lymphedema.

The Plan will allow coverage for DME supplies including those that are disposable, for members under the age of 18 when there is a clinical need and is ordered by a prescriber.

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

Note: *DME is different from prosthetic devices – see* **PROSTHETIC DEVICES** *in this section.*

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

Prior Authorization is required for Durable Medical Equipment and Prosthetic Devices items costing more than $1,000.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Well Connected if the retail purchase cost or cumulative rental cost of a single item will **exceed $1,000. To receive Network Benefits**, you must purchase or rent the DME from the vendor Well Connected identifies or purchase it directly from the prescribing network physician**. If Prior Authorization is not obtained as stated above, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Emergency Health Services

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

If you are admitted to a Hospital as a result of an Emergency directly from the Emergency room, the Benefits for an Inpatient Stay in a Network Hospital will apply. You must notify Well Connected within 48 hours or the same day of admission if possible.

Network Benefits will be paid for an Emergency admission to a Out-of-Network Hospital **as long as Well Connected is notified within 48 hours of the admission** or on the same day of admission if reasonably possible after you are admitted to an Out-of-Network Hospital. If you continue your stay in a Out-of-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Out-of-Network Benefits will apply.

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

When Covered Health Services are received from a Out-of-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Well Connected ***48 hours*** of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. **If Prior Authorization is not obtained within one business day, Benefits for the Inpatient Hospital Stay will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Enteral Nutrition

Benefits are provided for enteral formulas and low protein modified food products, administered either orally or by tube feeding as the primary source of nutrition, for certain conditions which require specialized nutrients or formulas. Examples of conditions include:

- Metabolic diseases such as phenylketonuria (PKU) and maple syrup urine disease.
- Severe food allergies.:
- Impaired absorption of nutrients caused by disorders affecting the gastrointestinal tract.

Benefits for prescription or over-the-counter formula are available when a Physician issues a prescription or written order stating the formula or product is Medically Necessary for the therapeutic treatment of a condition requiring specialized nutrients and specifying the quantity and the duration of the prescription or order. The formula or product must be administered under the direction of a Physician or registered dietitian.

For the purpose of this Benefit, “enteral formulas” include:

- Amino acid-based elemental formulas.
- Extensively hydrolyzed protein formulas.
- Modified nutrient content formulas.
- For the purpose of this Benefit, “severe food allergies” mean allergies which if left untreated will result in:
- Malnourishment.
- Chronic physical disability.
- Intellectual disability; or
- Loss of life.

Gender Identity Dysphoria

This benefit is for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnosis.

- Cross-sex hormone Therapy:
  - Cross-sex hormone therapy administered by a medical provider
  - Cross-sex hormone therapy dispensed from a pharmacy
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:
  - Male to Female
    - Breast augmentation
    - Clitoroplasty (creation of clitoris)
    - Colovaginalplasty
    - Labiaplasty (creation of labia)
    - Orchiectomy (removal of testicles)
    - Penectomy (removal of penis)
    - Urethroplasty (reconstruction of female urethra)
    - Vaginoplasty (creation of vagina)
  - Female to Male
    - Bilateral mastectomy or breast reduction
    - Colpectomy
    - Hysterectomy (removal or uterus)
    - Metoidioplasty (creation of penis, using clitoris)
    - Penile prosthesis
    - Phalloplasty (creation of penis)
    - Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
    - Scrotoplasty (creation of scrotum)
    - Testicular prosthesis implantation
    - Urethroplasty (reconstruction of male urethra)
    - Vaginectomy (removal of vagina)
    - Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements are as follows:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the covered person meets all of the following criteria:
  - Persistent, well-documented Gender Dysphoria.
  - Capacity to make a fully informed decision and to consent for treatment.
  - Must be 18 years or older.
  - If significant medical or mental health concerns are present, they must be reasonably well controlled.

You must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating

Gender Dysphoria, who have independently assessed the participant. The assessment must document that the participant meets all the following criteria.

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must be 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.
- Complete at least 12 months of successful continuous full-time real- life experience in the desired gender.
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Facial Feminization/Masculinization service covered with a lifetime maximum of $50,000

See **GLOSSARY MEDICAL** for more information on Gender Dysphoria.

Hearing Care

The Plan pays Benefits for routine hearing exams when services are received from a Provider in the Providers office.

Benefits for Hearing exams that are for Injury or Sickness are described in this section under Physician's Office Services.

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

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

Bone anchored hearing aids are a Covered Health benefit if they meet the following criteria:

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

Any combination of Network Benefits and Out-of-Network Benefits is limited to a $1,000 maximum per Covered Person. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 years.

External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure.

Home Health Care

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

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

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

Any combination of Network Benefits and Out-of-Network Benefits is limited to 120 visits per Covered Person per calendar year. One visit equals four hours of Skilled Care services.

Prior Authorization is required for Home Health Care services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Well Connected five business days **BEFORE** receiving services or as soon as reasonably possible. **If Prior Authorization from Well Connected is not obtained in advance, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Hospice Care

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

Prior Authorization is required for Hospice Care services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Well Connected ***five business days*** **BEFORE** receiving services. **If Prior Authorization from Well Connected is not obtained in advance, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Hospital – Inpatient Stay

Hospital Benefits are available for:

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

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

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

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

Prior Authorization is required for Hospital Inpatient services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Well Connected as follows:

- for elective admissions: **five business days BEFORE** admission or **as soon as reasonably possible**;
- for Emergency admissions (also termed non-elective admissions): **as soon as is reasonably possible.**

If Prior Authorization is not obtained as stated above, Benefits will be subject to a $150 reduction. ***Call the phone number on the back of you ID card.***

Infertility Services

The Plan pays Benefits for infertility services and associated expenses including:

- Physicians office visits and consultations;
- Assisted Reproductive Technologies (ART): in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), Intra Cytoplasmic Sperm Injection (ICSI);
- Insemination procedures: Artificial Insemination (AI) and Intrauterine Insemination (IUI);
- Embryo transportation related network disruption;
- Ovulation induction and controlled ovarian stimulation;
- Pre-implantation genetic testing (PGT-M or PGT-SR) for diagnosis of genetic disorders only;
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) – male factor associated surgical procedures for retrieval of sperm; and
- Cryopreservation – embryos

(Note: These Benefits do not apply to surrogacy services. See the EXCLUSIONS: PLAN BENEFITS NOT COVERED section for more details.)

Any combination of Network Benefits and Out-of-Network Benefits for infertility services is limited to a **$10,000** maximum per Covered Person per lifetime.

To be eligible for Benefits, the Covered Person must

- Must be under age 44, if female and using own eggs / oocytes
- Must be under age 55, if female and using donor eggs / oocytes

For treatment initiated prior to pertinent birthday, services will be covered to completion of initiated cycle.

Only charges for the following apply toward the infertility lifetime maximum:

- diagnostic services; and
- Related lab and x-ray;
- surgeons and assistant surgeons fees; and
- self-injections and oral Rx

The cost of any prescription medication treatment for in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures and zygote intrafallopian transfer (ZIFT) procedures does count toward the infertility lifetime maximum.

Fertility Preservation – when planned cancer or other medical treatment is likely to produce infertility/ sterility: Coverage is limited to: collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of eggs, oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are the responsibility of the member.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Well Connected ***five business days*** **BEFORE** receiving services. **If Prior Authorization from Well Connected is not obtained in advance, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Injections in a Physicians Office

Benefits are paid by the Plan for injections administered in the Physicians office, for example allergy immunotherapy, when no other health service is received. However, immunizations for personal travel are not covered.

Lab, X-Ray and Diagnostics – Outpatient

Services for Sickness and Injury-related diagnostic purposes received on an outpatient basis at a Hospital or Alternate Facility [or in a Physician's office] include:

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

Benefits include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under Physician Fees for Surgical and Medical Services.)
- Presumptive Drug Tests and Definitive Drug Tests.

Any combination of Network Benefits and Out-of-Network Benefits is limited to 18 Definitive Drug Tests and 18 Presumptive Tests per calendar year.

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

Prior Authorization is required specifically for Sleep Studies—Outpatient.

Lab, X-Ray and Major Diagnostics (such as CT, PET Scans, MRI, MRA, Nuclear Medicine, cardiology tests, etc.) – Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, cardiology tests and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility **will require Prior Authorization. Failure to obtain Prior Authorization may result in no coverage.**

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.
- Cardiology Services include:
  - Outpatient diagnostic catheterizations
  - Inpatient and outpatient electrophysiology implants
  - Outpatient echocardiograms and stress echocardiograms

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

Prior Authorization is required for all these services.

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a providers office or at an Alternate Facility.

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

- diagnostic evaluations and assessment;
- crisis intervention
- individual, family, therapeutic group and provider-based case management services; and
- medication management;
- referral services; and
- treatment planning;

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

AbleTo

If you are living with a medical condition (for example: cancer, diabetes, chronic pain, a recent cardiac incident, or others), you may qualify for AbleTo – an eight week program designed to help you feel better. AbleTo is a virtual behavioral health provider that offers private counseling sessions via phone or secure video chat and offers personalized tools to help you feel better through positive thinking, behavioral change and mindfulness. Services are covered at no cost to the member (treatment for members with HSA plans is subject to deductible) and you can participate anytime (24/7) from the comfort and privacy of home. To learn more, please visit ableto.com or call toll-free at **866-287-1802**. TTY users can dial **711**.

Special Mental Health Programs and Services

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

Prior Authorization is required for Mental Health inpatient services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from the MH/SUD Administrator to receive these Benefits in **ADVANCE** of any treatment. Please refer to **WELL CONNECTED (CASE MANAGEMENT)** for the specific services that require notification. **Without Prior Authorization, Benefits will be subject to a $150 reduction.** ***Call the phone number that appears on your ID card.***

Naturopathic Professional Services

The Plan covers Benefits for naturopathic professional services. Materials such as herbs and nutritional supplements are generally not covered by the Plan.

Benefits are limited to 20 visits per Covered Person per calendar year for Network and Out-of-Network Benefits combined.

Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider;
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.
- It also includes Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA).

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

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

- crisis intervention
- diagnostic evaluations and assessment;
- individual, family, therapeutic group and provider-based case management services;
- medication management;
- referral services;
- treatment planning

Prior Authorization is required for Neurobiological Disorder services including Applied Behavioral Analysis (ABA) Therapy.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from the MH/SUD Administrator in **ADVANCE** to receive these Benefits. Please refer to **WELL CONNECTED (CASE MANAGEMENT)RESOURCES TO HELP YOU STAY HEALTHY** for the specific services that require notification. **Without Prior Authorization, Benefits will be subject to a $150 reduction.** ***Call the phone number that appears on your ID card.***

Nutritional Counseling

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

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

Some examples of such medical conditions include:

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

Limited to 3 visits per lifetime per medical condition. When nutritional counseling services are billed as a preventive care service, these services will be paid as described under **PREVENTIVE CARE SERVICES** in this section.

Obesity Surgery

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

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 or 40 with co-morbid conditions; ***and***
- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years; ***and***
- you are over the age of 18.

In addition to meeting the above criteria, all the following must also be true:

- you have completed a 6-month Physician supervised weight loss program;
- you have completed a pre-surgical psychological evaluation; and

Note: For services to be covered they must be obtained at a UHC contracted facility.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in the **GLOSSARY MEDICAL** section and are not Experimental or Investigational or Unproven Services.

Benefits are **limited to one surgery** per lifetime unless there are complications to the covered surgery. Excessive Skin Removal (Panniculectomy) coverage is available when it is considered medically necessary.

Orthotics

The Plan covers Benefits for orthotics when prescribed by a Physician. These Benefits are limited to:

- shoe orthotics;
- arch supports;
- orthotic braces that stabilize an injured body part; and
- braces to treat curvature of spine.

Any combination of Network Benefits and Out-of-Network Benefits is limited to a $350 maximum per Covered Person per calendar year for foot orthotics.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

Pharmaceutical Products – Outpatient

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described under your Outpatient Prescription Drug Plan. **Note:** Benefits under this section do not include medications for the treatment of infertility.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, UnitedHealthcare may direct you to a designated dispensing entity with whom UnitedHealthcare has an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a designated dispensing entity and you/your provider choose not to obtain your Pharmaceutical Product from a designated dispensing entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at myuhc.com or by calling the telephone number on your ID card. UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication.

Physician Fees for Surgical and Medical Services

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

The Plan covers Benefits for artificial disc replacement surgery which includes lumbar and cervical (Levels 1 and 2). **Well Connected notification is required PRIOR to receiving services.** ***Call the phone number on the back of your ID card.***

Physicians Office Services

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

Benefits for Naturopaths are limited to 20 visits per calendar year. The visit limit applies to Network Benefits and Out-of-Network Benefits combined.

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

Pregnancy – Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury for certain Covered Persons. However, direct or indirect expenses incurred for a Dependent Child's pregnancy are not covered. This exclusion does not apply to prenatal services for which Benefits are provided under the Preventive Care Services benefit, including certain items and services under the United States Preventive Services Task Force requirements or the Health Resources and Services Administration (HRSA) requirement or care to save the life of the mother.

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

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

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

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

Please Note: A Retiree may not enroll an individual including a newborn as an Eligible Dependent unless in accordance with applicable time deadlines, such Eligible Dependent is or was declared to the Plan Administrator as eligible for coverage. To the extent at the time such Eligible Dependent is /was declared to as eligible for coverage but the Retiree at that time elects to suspend coverage in accordance with the Plan Administrator's procedures, the Retiree may later enroll such declared individual as an Eligible Dependent. Benefits for Dependent Children. Direct or indirect expenses incurred for a Dependent Child's pregnancy are not covered. (Bold) Please Note: This exclusion does not apply to prenatal services for which benefits are provided under the Preventive Care Services benefit, including certain items and services under the United States Preventive Services Task Force requirements or the Health Resources and Services Administration (HRSA) requirement of care to save the life of the mother. If you reside in the State of Massachusetts, the benefit coverage for a Dependent Child's pregnancy is different and the Plan covers additional benefits. If you have questions on which prenatal services for a Dependent Child pregnancy are covered, please contact the Claims Administrator at **800-842-1219**.

Prior Authorization is required for maternity care that exceeds the above specified delivery timeframes.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Well Connected **as soon as reasonably possible (ASAP)** if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. **If Prior Authorization from Well Connected is not obtained ASAP, Benefits for the extended stay will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Healthy moms and babies

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See **WELL CONNECTED RESOURCES TO HELP YOU STAY HEALTHY** section for details.

Healthy Pregnancy

Maternity Support Program

The Maternity Support Program offers information and support for expectant mothers throughout your pregnancy and after giving birth. When you enroll, you'll work closely with an experienced UnitedHealthcare maternity nurse who is available to answer your questions and help you with things like:

- Support to help you manage your health – physically and emotionally – before and after your baby is born.
- Choosing a doctor or nurse midwife, and helping you find a pediatrician or other specialist after your baby is born.
- Information to help you take care of yourself and the health of your baby – even if your pregnancy is considered high-risk.

Upon enrollment, Retirees take a health assessment to help identify any risks or special needs. Retirees also receive:

- **24-hour, toll-free support** — Retirees also have 24-hour, toll-free telephone access to experienced nurses who can answer questions or help Retirees learn and practice healthy pregnancy habits to protect their baby's well-being.
- **Dedicated maternity nurses** — Experienced obstetrics nurses will help determine what, if any, risks or complications could arise during pregnancy and will provide one-on-one support for high-risk cases
- **Post-delivery support** — After birth, there are outcome assessments for delivery, mother's well-being and postpartum depression.
- **Pregnancy educational materials** — Retirees receive important educational materials covering a wide range of topics based on their needs. Topics include nutrition, exercise, warning signs, things to avoid, fetal development, preparing for childbirth, breastfeeding, infant care and more.

If you enroll before 17 weeks gestation you'll also receive a welcome gift that includes:

- A choice of one book from several options
- Lavender lotion
- Lumen receiving blanket
- Massager
- Milestone stickers
- Onesie

Participation is voluntary. To take full advantage of the program, we recommend enrolling in the first trimester of your pregnancy however, you can enroll any time, up to your 34th week. To enroll, call **800-842-1219** and when prompted, say, "Healthy Pregnancy".

The Healthy Pregnancy App

Download the Healthy Pregnancy app for quick, on-the-go access to reliable information and resources to help you manage the health of you and your baby throughout your pregnancy. This app gives you:

- 24/7 nurse support through one-click connection – anytime, day or night
- Medically approved pregnancy information
- Symptom checker

- Information on what to expect during labor
- Help preparing for your next doctor visit
- Tracking tools and resources like a kick counter, cost estimator tools and more.

Download the app to take your first step toward a healthier pregnancy.

Neonatal Resource Services (NRS)

If your pregnancy has been identified as high-risk, Neonatal Resources Services (NRS) will connect you to an experienced obstetric nurse for high-risk management. The goal of NRS is to increase birth weight and avoid premature delivery. You'll receive one-on-one support from a nurse who can guide you through the first six weeks of your baby's life. Your health plan pays for neonatal intensive care unit (NICU) services provided by Designated Facilities participating in the NRS program. NRS provides guided access to a network of credentialed NICU providers and specialized nurse consulting services to manage NICU admissions.

In order to receive benefits under this program, the Network Provider must notify NRS or Personal Health Support if your newborn's NICU stay is longer than the mother's hospital stay.

Call **800-842-1219** for more information or to enroll.

Preventive Care Services

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

- evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Cologuard® test will also be covered as preventive for participants age of 50 and older, once every 3 years;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

***Note:** 3D mammograms or digital breast tomosynthesis are covered under preventive care.*

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card. You can also refer to: uspreventiveservicestaskforce.org/Page/Name/recommendations

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

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump.

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition

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

Private Duty Nursing – Outpatient

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

Prosthetic Devices

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

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Womens Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

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

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

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

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

Note: *Prosthetic devices are different from DME – see* **DURABLE MEDICAL EQUIPMENT (DME)** *in this section.*

Reconstructive Procedures

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

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

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

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without

improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Glossary section. Excessive Skin Removal (Panniculectomy) coverage is available and maybe considered reconstructive procedure when it is considered medically necessary.

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

Please remember that **you must obtain Prior Authorization** from Well Connected **five business days BEFORE** undergoing a Reconstructive Procedure. When **you** contact Well Connected, they can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always **excluded** from coverage. ***Call the phone number on the back of your ID card.*** *Also see* **WELL CONNECTED (CASE MANAGEMENT)** *earlier in this SPD.*

Rehabilitation Services – Outpatient Therapy

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

- cardiac rehabilitation
- chiropractic treatment:
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- occupational therapy;
- physical therapy;
- post-cochlear implant aural therapy;
- pulmonary rehabilitation;
- speech therapy; and
- vision therapy;

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physicians office or on an outpatient basis at a Hospital or Alternate Facility.

Note: Any combination of manipulative Treatment and physical therapy for new low back pain:100% for the first 3 visits in a year with an in-network provider.

The Plan pays Benefits for the following:

- Autism Spectrum Disorders;
- cancer;
- Congenital Anomaly, or is needed following the placement of a cochlear implant;
- Sickness;
- speech therapy only when the speech impediment or dysfunction results from Injury; and
- stroke;

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Hinge Health Virtual Physical Therapy

Hinge Health Virtual Physical Therapy program can help you conquer back and joint pain. Best of all, Hinge Health's programs are provided at no cost to you and your eligible dependents enrolled in a Lumen medical plan.

Eligibility

To be eligible for the Hinge Health programs, you, and your eligible dependents must meet each of the following requirements: (i) be enrolled in a UHC or Surest health plan, (ii) be age 18 or older (iii) be located in the United States, and (iiii) be approved through the clinical suitability evaluation performed by Hinge Health prior to enrollment.

Hinge Health provides all the tools you need to get moving again from the comfort of your home. Through the Hinge Health Digital Musculoskeletal (MSK) Clinic, participants have access to personalized MSK care programs depending on their specific MSK needs. Participants will register online through the Hinge Health website or app, complete a clinically validated screener to determine which program best fits their MSK needs. The programs include:

- Prevention - Program designed to increase education with regards to key strengthening and stretching activities around healthy habits. The Prevention program is software based and offered through the Hinge Health app.
- Chronic - Program designed to address long term back and joint pain along with Women's pelvic health conditions. Program includes personalized exercise therapy sessions guided by wearable sensors, 1:1 access to a personalized health coach, personalized education content, and behavioral health support.
- Acute - Program designed to address recent injuries which includes live virtual sessions with a dedicated licensed Physical Therapist along with software guided rehabilitation and education.
- Surgery - Program designed to address pre/post surgery rehab for the most common MSK Surgeries which includes personalized exercise therapy sessions guided by wearable sensors, 1:1 access to a personalized health coach and physical therapist, personalized education content, and behavioral health support.
- Expert Medical Opinion - Service offering second opinions for elective MSK procedures.

To get started with Hinge Health, visit lumen.com/hingehealth to enroll. If you have any questions regarding Hinge Health, email help@hingehealth.com or call **(855) 902-2777**.

Kaia

Kaia Health offers a next generation care solution for musculoskeletal pain, delivered on-demand and available 24/7 through a mobile app on your smartphone or tablet. You can do physical therapy from anywhere. The new Kaia app is here to help with pain relief at no extra cost as part of your health plan.

Some of the benefits include 1-on-1 coaching with certified professionals, workouts tailored to you, lessons to help you recognize where pain is coming from, strengthening exercises plus relaxation techniques for pain management. Kaia uses technology to guide your movements and ensure you're doing exercises correctly.

For questions you can call Kaia at **888-866-4024** or at startkaia.com/uhc

Habilitative Services (Federal Legislation – Essential Health Benefits). The Essential Health Benefits (EHB) provision of the Affordable Care Act (ACA) introduced a new coverage category for Habilitative services (Occupational therapy, physical therapy, speech therapy).

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

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

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

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Covered Persons condition is clinically improving as a result of the habilitative service.

When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

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

Scopic Procedures – Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received at a Hospital, Alternate Facility or in a Physicians office.

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

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

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under Surgery. For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Prior Authorization is required for Out-of-Network Physical, Speech and Occupational Therapy

2nd.MD

See the **Retiree General Information SPD** for more information.

Retirees, and enrolled spouses, domestic partners and dependents have access to 2nd.MD consultations with board-certified, expert doctors for a voluntary expert second opinion via phone or video all within a matter of days and at no cost to you.

Note: Lumen requires that you consult with 2nd.MD prior to a hip, shoulder, knee or spine surgery (on a non-emergency basis). If you don't seek a second opinion for these surgeries, you will be responsible for an additional $500 of out-of-pocket cost, whether or not you've met your annual deductible.

For more information contact 2nd.MD and speak to a leading doctor. Visit 2nd.md/Lumen or call **866.269.3534**

Second Surgical Opinion

Covered at 100% for up to two (i.e., a second opinion and third opinion).

Second Surgical Opinion Review. Second Surgical Opinion Review may be required for inpatient surgeries when using Out-of-Network providers. If you are seeking care from a Network physician, the physician will contact UnitedHealthcare directly.

You must contact UnitedHealthcare if a second opinion is required. If a second opinion is required, UnitedHealthcare can assist you with the names of up to three doctors in your area from which you can choose to provide the second opinion. The cost for this opinion is covered at 100% and is not subject to the Annual Deductible.

If you fail to obtain a second surgical opinion when advised to do so and UnitedHealthcare determines that your surgery is not a covered health service, your benefits may be denied. If the first reviewing physician agrees with the treating physician that the proposed inpatient surgery is appropriate, then UnitedHealthcare will authorize payment. If the first reviewing physician does not agree with the treating physician that the proposed inpatient surgery is appropriate, then you may request a third opinion from a physician of your choice as to whether the proposed procedure is appropriate. If approved in advance by UnitedHealthcare, the cost for this opinion is covered at 100% and is not subject to the Annual Deductible.

If you do not request the second physician review, or the second physician review differs from that of the first reviewing physician, UnitedHealthcare shall determine whether the proposed inpatient surgery is a covered health service. UnitedHealthcare in their determination will take into account the opinions of the treating physician and the first reviewing physician.

Even if a second opinion is required, the final decision about whether you should have surgery is up to you and your doctor, not UnitedHealthcare. However, if UnitedHealthcare determines that your surgery is not a covered service, plan benefits could be denied.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective

alternative to an Inpatient Stay in a Hospital; and

- you will receive skilled care services that are not primarily Custodial Care.

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

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

You are expected to improve to a predictable level of recovery.

Note: *The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in the* **GLOSSARY MEDICAL** *section.*

Any combination of Network Benefits and Out-of-Network Benefits is limited to 120 days per Covered Person per calendar year.

Prior Authorization is required for Skilled Nursing Facility/Inpatient Rehabilitation Facility services.

Please remember, for Out-of-Network Benefits, **you must obtain Prior Authorization** from Well Connected as follows:

- for elective admissions: ***five business days*** **BEFORE** admission;
- for Emergency admissions (also termed non-elective admissions**): as soon as is reasonably possible**.

If Prior Authorization from Well Connected is not obtained as stated above, Benefits for the extended stay will be subject to a $150 reduction. ***Call the phone number on the back of your ID card.***

Spinal Treatment

The Plan pays Benefits for Spinal Treatment when provided by a Network or Out-of-Network Spinal Treatment specialist in the specialists office. Covered Health Services include chiropractic and osteopathic manipulative therapy.

The Plan gives the Claims Administrator (UHC) the right to deny Benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Benefits include diagnosis and related services. The Plan limits any combination of Network Benefits for Spinal Treatment to one visit per day up to 20 visits per calendar year.

Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a providers office or at an Alternate Facility.

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

- diagnostic evaluations and assessment;
- treatment planning;

- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention; and
- detoxification.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan.

You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Prior Authorization is required for Special Substance Use Disorder Programs and Services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from the MH/SUD Administrator **in advance to receive these Benefits**. Please refer to **WELL CONNECTED (CASE MANAGEMENT)** for the specific services that require Prior Authorization. **Without advance Prior Authorization, Benefits will be subject to a $150 reduction.** ***Call the phone number that appears on your ID card.***

Surgery – Outpatient

Out-of-network outpatient surgery centers and facilities will no longer be covered.

- Visit myuhc.com and/or call the number in the back of your medical card to confirm that your facility is in the network. If you do not have access to an in-network provider within a 30-mile radius of your home, you may qualify for a Network Gap. In this case, you can receive care from a closer provider who is not part of the network and that care will be covered as if the provider were in-network. Be sure to call your health plan member services number listed on your medical plan ID card before you start services with a provider that may warrant coverage through a “network gap exception. **Network Gap exceptions will not be granted after you have received services.**

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- All outpatient surgeries have to be at a UHC contracted facility;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

Prior Authorization is required for diagnostic catherization and electrophysiology implant and sleep apnea outpatient surgeries.

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

Specialty Management Solutions

Specialty Management Solutions (SMS) is a holistic outpatient surgery solution that opens the door to affordable, quality specialty care. SMS connects Retirees and their eligible family members to surgical specialists in their communities who help them choose the most appropriate setting for their procedures. Specialists in the SMS alliance use ambulatory surgery centers (ASC), which means Retirees can receive outpatient surgical care and other outpatient procedures resulting in cost savings.

The SMS program is available at no cost to the member.

Specialties include:

- Cardiovascular
- ENT
- Gastrointestinal
- General Surgery
- MSK/Spine
- Ophthalmology
- Orthopedic
- Pain Management
- Podiatry
- Urology
- Women's Health

Medical appointments and treatments remain member's responsibility and are subject to plan benefits.

To speak to an SMS surgical care advocate, members may call SMS direct at **833-344-1640** or go to specialistmanagementsolutions.com, for more information.

2nd.MD

$500 additional responsibility will apply to hip, knee, shoulder, and spine surgeries if a 2nd MD consult is not completed.

Prior Authorization is required for diagnostic catheterization and electrophysiology implant and sleep apnea outpatient surgeries.

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

Temporomandibular Joint Dysfunction (TMJ)

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

Therapeutic Treatments – Outpatient

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

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

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

Benefits under this section include:

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

Prior Authorization is required for intensity modulated radiation therapy, and MR-guided focused ultrasounds.

Transplantation Services

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

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

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

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

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

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

Note: The services described under the Travel and Lodging Assistance Program are Covered Health Services only in connection with transplant services received at a Designated Provider

Prior Authorization is required for Transplantation services.

Please remember for Out-of-Network Benefits, **you must notify** Well Connected **as soon as the possibility (ASAP)** of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). **If Well Connected is not notified ASAP, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Note: *The services described under Travel and Lodging are Covered Health Services only in connection with Transplantation services when* ***received at a Designated Facility or Centers of Excellence***.

Travel and Lodging

Well Connected will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments (CRS).

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

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

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility or Center of Excellence. The Claims Administrator (UHC) must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

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

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

Support in the event of serious illness

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

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in the **GLOSSARY MEDICAL** section. When Urgent Care services are provided in a Physicians office, the Plan pays Benefits as described under **Physicians Office Services** earlier in this section.

Wigs

The Plan pays Benefits for one wig per lifetime and other scalp hair prosthesis for loss of hair resulting from Alopecia, Cancer or chemotherapy treatments.

Additional Programs for Related Benefits

There are several benefit related programs that you should be aware of that are associated with certain services/diagnosis as indicated in the listing of Benefits above. Many of these require Prior Authorization and/or require use of a Designated Facility. The list below indicates where to find these programs throughout this section above.

- Cancers Resource Services (CRS) —See **Cancer Resource Services (CRS)**
- Neonatal (NRS) -- See **Pregnancy – Maternity Services**
- Healthy Moms and Babies -- See **Pregnancy – Maternity Services**
- Healthy Pregnancy Program – See **Pregnancy – Maternity Services**
- Transplant Services – See **Transplantation Services**
- Congenital Heart Disease Services – See **Congenital Heart Disease (CHD) Surgeries**

UHC – VIRTUAL VISITS

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons, through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to myuhc.com or by calling the telephone number on your ID card.

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

Benefits under this section do not include email, or fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

Protections from Disclosure of Medical Information

The Claims Administrator (UHC) is required by law to maintain the privacy and security of your personally identifiable health information. Although the Well Connected Program and may use aggregated and depersonalized information it collects to design a program based on identified health risks in the workplace, The Well Connected Program will never disclose any of your personal information either publicly or to, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Well Connected Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Well Connected Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Well Connected Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Well Connected Program or receiving an incentive. Anyone who receives your information for purposes

of providing you services as part of the Well Connected Program will abide by the same confidentiality requirements. Your health information may be shared with the Claims Administrator (UHC)'s wellness coaches, nurses, and doctors, whom are involved in administering the Well Connected Program and health plan and may also be shared with the Claims Administrator (UHC)'s vendors and subcontractors in accordance with applicable laws, including HIPAA, as necessary to administer the Well Connected Program or health plan. Anyone who receives your information for purposes of providing you services as part of the Well Connected program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the Well Connected Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Well Connected Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and the event of a data breach involving information you provide in connection with the Well Connected Program, the Plan Administrator will notify you within the time periods required by applicable laws, including HIPPA.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Well Connected Program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Integrity Line at **800-333-8938** or email at IntegrityLine@.com.

WELL CONNECTED RESOURCES TO HELP YOU STAY HEALTHY

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

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

Additional Incentive Program Details

Health Survey

You and your Spouse/Domestic Partner who are enrolled in a medical plan are invited to learn more about your health and wellness at myuhc.com and are encouraged to participate in the online health survey. The health survey is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

To find the health survey, log in to www..com/iamwellconnected. If you need any assistance with the online survey, please call the number on the back of your ID card.

Your health survey is kept confidential. Completing the survey will not impact your Benefits or eligibility for Benefits in any way. does not receive the results or data from your survey.

Condition Management program

If you have been diagnosed with certain chronic medical conditions: heart failure, coronary artery disease, diabetes, asthma and/or Chronic Obstructive Pulmonary Disease (COPD), you may be eligible to participate in a disease management program at no additional cost to you. The programs are designed to support you. This means that you will receive free educational information through the mail and may even be called by a

registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

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

Examples of support topics include:

- Education about the specific disease and condition.
- Medication management and compliance.
- Reinforcement of on-line behavior modification program goals.
- Preparation and support for upcoming Physician visits.
- Review of psychosocial services and community resources.
- Caregiver status and in-home safety.
- Use of mail-order pharmacy and Network providers.
- Participation is completely voluntary and without extra charge.

Note: If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

Personal /Telephonic Coaching

Wellness Coaching provides a blended model of personal coaching, self-paced online learning and digital support to help you meet your personal health goals. You have access to:

- Online and telephonic coaching options
- Access to online courses, 24/7, guided discussion, live chat or secure message with a Wellness Coach
- Personalized action plan
- Choose the goals you want to focus on:
  - Eating better
  - Reducing Stress
  - Quit Tobacco
  - And more

For information and to get started call 800-478-1057.

Weight Watchers Program

Weight Watchers offers a scientifically proven program for weight loss and wellness, with Digital, Studio and Personal coaching solutions to help meet your goals. For more than 55 years, Weight Watchers has helped millions lose weight with the latest nutritional and behavior change science.

There easy-to-use app puts it all in the palm of your hand: quick food and activity tracking, 24/7 Live Coaching, goal-setting, 8,000+ recipes, a barcode scanner, and supportive network of members, and more. If you would like to additional information regarding the Weight Watchers Program visit weightwatchers.com/us/.

Retirees and spouses/domestic partners who are enrolled in a UHC or Surest medical plan will be eligible to receive up to $55/month for participating in the Weight Watcher Program. A prescription for your health care provider is required advising of a weight management related medical condition or illness (e.g. heart disease, obesity, hypertension) to be eligible for reimbursement per IRS Code Section 213(d), along with a receipt and a Weight Watchers Reimbursement Form which can be found on the Company Intranet. lumenbenefits.com

EXCLUSIONS: PLAN BENEFITS NOT COVERED

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition. The exclusions listed below apply to the Plan Benefits section and are subject to change from time to time and overtime. In addition, exclusions from coverage listed in the **EXCLUSIONS: PRESCRIPTION DRUG PLAN BENEFITS NOT COVERED** section also apply to this section.

When Benefits are limited within any of the Covered Health Services categories described in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section, those limits are stated in the corresponding Covered Health Service category in the **Plan Highlights (CDHP Network and Virtual Networks)** section and the **COVERED CDHP (WITH HRA) BENEFITS** section. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the **Plan Highlights (CDHP Network and Virtual Networks)** section. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says “this includes,” or “including but not limiting to”, it is not the Claims Administrator (UHC)’s intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list “is limited to.” This list changes from time to time and over time. To assure that a service or product is a Covered Expense, contact the number on the back of your ID card for approval.

Alternative Treatments

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

Comfort and Convenience

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

1. television;
2. telephone;
3. air conditioners;
4. beauty/barber service;
5. guest service;

6. air purifiers and filters;
7. batteries and battery chargers (unless it's associated with a medical device/procedure that is considered medically necessary);
8. dehumidifiers and humidifiers;
9. ergonomically correct chairs;
10. non-Hospital beds and comfort beds;
11. devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under Durable Medical Equipment in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section; and
12. home remodeling to accommodate a health need (including, but not limited to, ramps, swimming pools, and elevators).

Dental

1. dental care, except as identified under Dental Services – Accident Only in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section;

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section.

   Endodontics, periodontal surgery and restorative treatment are excluded.
2. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances;
3. preventive dental care;
4. diagnosis or treatment of the teeth or gums. Examples include:
   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;
5. dental implants and braces;
6. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

   This exclusion does not apply to dental sedation and general anesthesia when a Physician determined to be medically necessary or which Benefits are available under the Plan, as identified in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section; and
7. treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Drugs

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

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;
2. self-injectable medications. (This exclusion does not apply to medications which, due to their characteristics, as determined by the Claims Administrator (UHC), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);
3. non-injectable medications given in a Physicians office except as required in an Emergency and consumed in the

Physicians office; and

4. over the counter drugs and treatments. Certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year;

5. certain New Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or the Claims Administrator's designee, but no later than December 31st of the following calendar year;

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

6. Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

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

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in the **GLOSSARY MEDICAL** section.

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

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under Diabetes Services in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section. Routine foot care services that are not covered include:
   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:
   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and
   - other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

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

3. treatment of flat feet;
4. treatment of subluxation of the foot;
5. shoe inserts when not prescribed by a Physician;
6. arch supports when not prescribed by a Physician;
7. shoes (standard or custom), lifts and wedges when not prescribed by a Physician; and
8. shoe orthotics when not prescribed by a Physician.

Gender Dysphoria

Services considered not medically necessary will be denied. The following procedures are considered cosmetic and generally are not covered when not medically necessary. This list includes but is not limited to:

1. Abdominoplasty.
2. Body contouring, such as lipoplasty.
3. Calf implants.
4. Liposuction.
5. Pectoral implants for chest masculinization.
6. Skin resurfacing.

Please contact UnitedHealthcare for more details regarding this benefit.

Medical Supplies and Appliances

1. devices used specifically as safety items or to affect performance in sports- related activities.
2. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to: elastic stockings, ace bandages, diabetic strips, and syringes.

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section; or
   - diabetic supplies for which Benefits are provided as described under Diabetes Services in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section
3. tubings, nasal cannulas, connectors and masks that are not used in connection with DME;
4. orthotic appliances that straighten or re-shape a body part (including some types of braces). Examples of excluded orthotic appliances and devices include, but are not limited to, foot orthotics when not prescribed by a Physician or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease;
5. cranial banding; This exclusion does not apply to: Cranial Helmet when it is needed to prevent surgery when the condition will not self-correct but worsen over time. ;
6. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under Ostomy Supplies in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section.

Mental Health/Substance Use Disorder

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

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

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

disorder, and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.
8. on-Medical 24-Hour Withdrawal Management.
9. High intensity residential care, including American Society of Addiction Medicine (ASAM) Criteria, for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment

Nutrition and Health Education

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;
2. nutritional counseling for either individuals or groups, except as identified under Diabetes Services, and except as defined under Nutritional Counseling in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section;
3. food of any kind, infant formula, standard milk-based formula, and donor breast milk. This exclusion does not apply to enteral formula and other modified food products for which Benefits are provided as described under **Enteral Nutrition**;
4. health club memberships and programs, and spa treatments; and
5. health education classes unless offered by the Claims Administrator (UHC) or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

1. Cosmetic Procedures, as defined in the **GLOSSARY MEDICAL** section, are excluded from coverage. Examples include:
   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;
3. wigs except for chemotherapy treatment, Cancer or Alopecia diagnosis, in which case the Plan pays up to a maximum of one wig per Covered Person per lifetime; and
4. treatments for hair loss;
5. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;
6. varicose vein treatment of the lower extremities, when it is considered cosmetic; and
7. treatment of benign gynecomastia (abnormal breast enlargement in males).

Pregnancy and Infertility

1. surrogate parenting expenses (non-Covered Person);
2. the reversal of voluntary sterilization;
3. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
4. impregnation or fertilization charges for surrogate donor (actual or attempted);
5. prenatal (with the exception of the prenatal services for which Benefits are provided under the Preventive Care Services benefit, including certain items and services under the United States Preventive Services Task Force requirements or the Health Resources and Services Administration (HRSA) requirement) labor and delivery coverage for Dependent Children;
6. elective surgical, non-surgical or drug induced Pregnancy termination;

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, missed abortion (commonly known as a miscarriage), incest or rape. (***Note:*** *Only incest or rape would apply to services for a Dependent Child*)
7. services provided by a doula (labor aide);
8. parenting, pre-natal or birthing classes.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or Child;
2. a provider may perform on himself or herself;
3. performed by a provider with your same legal residence;
4. ordered or delivered by a Christian Science practitioner;
5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;
6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;
7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and
8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
   - prior to ordering the service; or
   - after the service is received.

   This exclusion does not apply to mammography testing.

Services Provided under Another Plan

Services for which coverage is available:

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

Transplants

1. health services for organ and tissue transplants,
   - except as identified under Transplantation Services in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section;
   - determined by Well Connected not to be proven procedures for the involved diagnoses; and
   - not consistent with the diagnosis of the condition;
2. health services for transplants involving animal organs;
3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and
2. travel or transportation expenses, even if ordered by a Physician, except as identified under Travel and Lodging in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plans discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under Ambulance Services in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section.

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;
2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
3. purchase cost and associated fitting charges for eyeglasses or contact lenses; *This exclusion does not apply to the first pair of contacts or lenses following cataract surgery.*
4. bone anchored hearing aids except when either of the following applies:
   - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
   - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions; and
5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition. The exclusions listed below are subject to change from time to time and over time.

1. autopsies and other coroner services and transportation services for a corpse;
2. Biofeedback
3. charges for:
   - missed appointments;
   - room or facility reservations; completion of claim forms; record processing; or
   - services, supplies or equipment that are advertised by the Provider as free;

4. charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency;
5. charges prohibited by federal anti-kickback or self-referral statutes;
6. chelation therapy, except to treat heavy metal poisoning;
7. Custodial Care as defined in the **GLOSSARY MEDICAL** section, or services provided by a personal care assistant;
8. diagnostic tests that are:
   - delivered in other than a Physician's office or health care facility; and
   - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;
9. Domiciliary Care, as defined in the **GLOSSARY MEDICAL** section;
10. growth hormone therapy, except for dwarfism secondary to pituitary gland failure;
11. expenses for health services and supplies:
    - that do not meet the definition of a Covered Health Service in the **GLOSSARY MEDICAL** section; that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
    - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends; for which you have no legal responsibility to pay, or
    - for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan; that exceed Eligible Expenses or any specified limitation in this SPD;
    - for which an Out-of-Network provider waives the Annual Deductible or Coinsurance amounts;
12. foreign language and sign language services;
13. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;
14. health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

    For the purpose of this exclusion, a complication is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition.

    Examples of a complication are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.
15. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer). Appliances for snoring are always excluded;
16. outpatient surgeries performed at facility not contracted by UHC
17. private duty nursing received on an inpatient basis;
18. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under Hospice Care in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section;
19. rest cures;
20. speech therapy to treat stuttering, stammering, or other articulation disorders;
21. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, Sickness, stroke, cancer, autism spectrum disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant as identified under Rehabilitation Services – Outpatient Therapy and Manipulative Treatment in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section;
22. Spinal Treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies;
23. storage of blood, umbilical cord or other material for use in a Covered Health Service, except if needed for an imminent surgery;
24. the following treatments for obesity:

- non-surgical treatment, even if for morbid obesity; and
- surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under Obesity Surgery in the **ADDITIONAL BENEFIT COVERAGE DETAILS** section; and

25. treatment of hyperhidrosis (excessive sweating).
26. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
27. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition the **GLOSSARY MEDICAL**. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
    - Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
    - Medically Necessary.
    - Described as a Covered Health Service in this SPD.
    - Not otherwise excluded in this SPD.

PRESCRIPTION DRUGS

Prescription Drug Coverage

Within this section, references to the Claims Administrator (UHC) only refer to UnitedHealthcare. The table below provides an overview of the Plan's Prescription Drug coverage. It includes Coinsurance amounts that apply when you have a prescription filled at a Network or Out-of-Network Pharmacy (after your deductible has been met). For detailed descriptions of your Benefits, refer to **Retail** and **Mail Order** in this section. Pharmacy coinsurance will apply to the annual Out-of-Pocket Maximum.

Prescription Drug Products on the List of Preventive Medications - as written by the provider, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits will bypass deductible and apply the appropriate coinsurance by tier.

Covered Health Services[1]	**Percentage of Prescription Drug Charge Payable by the Plan:**	**Percentage of Predominant Reimbursement Rate Payable by the Plan:**
	Network	**Out-of-Network**
Retail[2] – up to a 30-day supply		
• tier-1	85%	50%
• tier-2	80%	50%
• tier-3	70%	50%
• tier-4	60%	50%
Retail Pharmacy Maintenance Prescription Drugs	**After 2 fills at retail, you will need to refill your maintenance medication prescriptions with OptumRx Mail Service Pharmacy or you will pay the full cost of the medication. See Mail Order coinsurance amount below.**	

Covered Health Services[1]	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Out-of-Network
Mail order – up to a 90-day supply		
• tier-1	85%	Not Covered
• tier-2	80%	Not Covered
• tier-3	70%	Not Covered
• tier-4	60%	Not Covered
Specialty Prescription Drugs – up to 30-day supply		
• tier-1	85%	Not Covered
• tier-2	80%	Not Covered
• tier-3	70%	Not Covered
• tier-4	60%	Not Covered

[1]**You must obtain authorization from UnitedHealthcare to receive full Benefits for certain Prescription Drugs.** Otherwise, you may pay more out-of-pocket. See **PRIOR AUTHORIZATION/MEDICAL NECESSITY REQUIREMENTS** for details.

[2]The Plan pays Benefits for **SPECIALTY PRESCRIPTION DRUGS** as described last in the above table.

Note: The Coordination of Benefits provision described in the **COORDINATION OF BENEFITS (COB)** section, does not apply to covered Prescription Drugs as described in this section. Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card) – Network Pharmacy

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

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

Coinsurance for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug at a Non- Network Pharmacy is a percentage of the Predominant Reimbursement Rate.

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

- the applicable Coinsurance;
- the Network Pharmacys Usual and Customary Charge for the Prescription Drug product; or
- the Prescription Drug Charge for that Prescription Drug Product.

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

- the applicable Coinsurance; or
- the Prescription Drug Charge for that particular Prescription Drug.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting the Claims Administrator (UHC) at the toll-free number on your ID card or by logging onto myuhc.com.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Coinsurance. However, some drugs require prior approval before the prescription can be obtained, as described later under **PRIOR AUTHORIZATION/MEDICAL NECESSITY REQUIREMENTS** in this section below. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Coinsurance that applies will reflect the number of days dispensed, or days the drug will be delivered;
- for a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Coinsurance for each cycle supplied or days the drug will be delivered;
- Oral and self-injectable infertility Prescription Drugs apply to the lifetime Benefit maximum of $15,000

Note: *Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.*

Mail Order

You will need to use OptumRx Mail Service pharmacy for most maintenance medications. Through OptumRx Mail Service Pharmacy, you receive convenient, safe and reliable service, including:

- Delivery of up to a 3-month supply of your medication right to your mailbox
- Flexible delivery anywhere in the U.S. with no charge to you for standard shipping
- Educational information about your prescriptions with each shipment
- Access to pharmacists 24 hours a day, seven days a week to answer your medication questions

In order to transition, you will be allowed only two fills before you will need to use OptumRx Mail Service pharmacy for most maintenance medications. After two fills at a participating retail pharmacy, you must begin ordering your maintenance prescriptions through the ***mail order or you will pay the full cost of the medication***.

The 100% cost will not apply to your Out-of-Pocket Maximum and will not be a covered claim. **You will continue to pay this cost even if you have met your Out-of-Pocket Maximum unless you switch to mail order.**

This applies to many maintenance medications with the exception of specialty, compounds and controlled substances. Please refer to myuhc.com for information on specific drugs which apply to the mail service program. You may also contact the member services phone number on the back of your health plan ID card.

However, if you find your covered maintenance medication for a lower cost at a retail pharmacy and choose to pay cash for the covered prescription, you can submit the claim for review – see **CLAIMS PROCEDURES** for information regarding how to file a claim.

When you submit a claim on this basis, the amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drugs from a Network Pharmacy) or the amount you submit, whichever is lower, less the required Copayment and/or Coinsurance any Deductible that applies.

In addition, some drugs require prior approval before the prescription can be obtained, as described later under **PRIOR AUTHORIZATION/MEDICAL NECESSITY REQUIREMENTS** in this section below.

Getting Started

Option 1: Call the phone number on the back of your plan ID card.

Member Services is available 24 hours a day, seven days a week to help you start using mail service. Please have your medication name and doctor's telephone number ready when you call.

Option 2: Talk to your doctor before your prescriptions must be switched to OptumRx.

Tell your physician you want to use OptumRx for home delivery of your maintenance medications. Be sure to ask for a new prescription written for up to a 3-month supply with three refills to maximize your plan benefits. Then you can either:

- Mail in your written prescriptions along with a completed order form.
- Ask your doctor to call **1-800-791-7658** with your prescriptions or to fax them to **1-800-491-7997**.

Option 3: Log on to myuhc.com

You can get started by

- Clicking on "Manage My Prescriptions" and selecting "Transfer Prescriptions"
- Select the medications you would like to transfer
- Print out the pre-populated form and bring this to your doctor
- Ask your doctor to call or fax in the prescriptions with the order form

Once OptumRx receives your complete order for a new prescription, your medications should arrive within ten business days – completed refill orders should arrive in about seven business days. If you need your medication right away, ask your doctor for a 1-month supply that can be immediately filled at a participating retail pharmacy. You can avoid this step by allowing sufficient time for your prescriptions to be moved to OptumRx.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturers packaging size or based on supply limits.

These supply limits do not apply to Specialty Prescription Drugs. Specialty Prescription Drugs from a mail order Network Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drugs.

You may be required to fill an initial Prescription Drug order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: *To maximize your benefit, ask your Physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any prescription order or refill if you use the mail order service, regardless of the number of days supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.*

Designated Pharmacy

If you require certain Prescription Drugs, the Claims Administrator (UHC) may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Please see **GLOSSARY – PRESCRIPTION DRUGS** in this SPD for definitions of Designated Pharmacy.

Specialty Prescription Drugs

You will be directed to a Designated Pharmacy and if you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid and you will be responsible for paying all charges.

Please see **GLOSSARY – PRESCRIPTION DRUGS** in this section for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the tables at the beginning of this section for details on Specialty Prescription Drug supply limits.

Note: To lower your out-of-pocket Prescription Drug costs: Consider tier-1 Prescription Drugs, if you and your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

The Claims Administrator (UHC) Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether supply limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are most cost effective for specific indications as compared to others, therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed.

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

The PDL Management Committee may periodically change the placement of a Prescription Drug among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

This means you should carefully review with your prescribing physician whether a Prescription Drug is covered and if so, at what tier. You can also call the number on the back of your ID card to obtain this information.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)

The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug Benefit.

Prior Authorization/Medical Necessity Requirements

Due to the high cost and specific condition treatment requirements that may be associated with medications, Prior Authorization/Medical Necessity Review may be applied to ensure these medications are being used appropriately and at the right time for a specific condition.

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Provider, your pharmacist or you to notify the Claims Administrator (UHC) for Prior Authorization or Medical Necessity approval. The Claims Administrator (UHC) will determine if the Prescription Drug, is in accordance with approved guidelines:

- a Covered Health Service as defined by the Plan;
- Medically Necessary and meets clinical guidelines, as defined in the **GLOSSARY – PRESCRIPTION DRUGS** section under Prior Authorization
- not Experimental or Investigational or Unproven, as defined in the **GLOSSARY – PRESCRIPTION DRUGS** section. If approved, the prior authorization will need to be reviewed every 12 months

The Plan may also require you to notify UnitedHealthcare so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with its approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization as required.

Out-of-Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Out-of-Network Pharmacy, you or your Physician are responsible for notifying the Claims Administrator (UHC) as required.

If prior authorization is not obtained from the the Claims Administrator (UHC) before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Charge) will not be available to you at an Out-of-Network Pharmacy. If prior authorization is not obtained from the the Claims Administrator (UHC) before you purchase the Prescription Drug; you can request reimbursement after you receive the Prescription Drug – see **CLAIMS PROCEDURES**, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator (UHC) before the Prescription Drug was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drugs from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drugs from a Out-of-Network Pharmacy), less the required Copayment and/or Coinsurance any Deductible that applies.

To determine if a Prescription Drug requires prior authorization, either visit myuhc.com or call the toll-free number on your ID card. The Prescription Drugs requiring prior authorization are subject to the Claims Administrator (UHC) periodic review and modification. Benefits may not be available for the Prescription Drug after the Claims Administrator (UHC) reviews the documentation provided and determines that the Prescription Drug is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at myuhc.com or by calling the toll-free number on your ID card.

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to **CLAIMS PROCEDURES**.

Limitation on Selection of Pharmacies

If the Claims Administrator (UHC) determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator (UHC) will select a single Network Pharmacy for you.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit myuhc.com or call the phone number on the back of your ID card. Whether or not a Prescription Drug has a supply limit is subject to the Claims Administrator (UHC) periodic review and modification.

Note: *Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator (UHC) have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per months supply.*

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name Drug may change. As a result, your Coinsurance may change. You will pay the Coinsurance applicable for the tier to which the Prescription Drug is assigned.

Special Programs

Lumen and the Claims Administrator (UHC) may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at myuhc.com or by calling the number on the back of your ID card.

Smoking Cessation Products

Coverage for prescription smoking cessation products (including Chantix, Bupropion, Nicotrol, and Zyban) are covered at 100% by the Plan for up to 90 days per calendar year. See **WELL CONNECTED RESOURCES TO HELP YOU STAY HEALTHY** above for more information.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug was prescribed by a specialist physician. You may access information on which Prescription Drugs are subject to Benefit enhancement, reduction or no Benefit through the Internet at myuhc.com or by calling the telephone number on your ID card.

Step Therapy

Certain Prescription Drugs for which Benefits are described in this section or pharmaceutical products for which Benefits are described under your medical Benefits are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drugs and/or pharmaceutical products you are required to use a different Prescription Drug(s) or pharmaceutical products(s) first.

You may determine whether a particular Prescription Drug or pharmaceutical product is subject to step therapy requirements by visiting myuhc.com or by calling the number on the back of your ID card.

Rebates and Other Discounts

The Claims Administrator (UHC) and Lumen may, at times, receive rebates for certain drugs on the PDL. The Claims Administrator (UHC) **does not** pass these rebates and other discounts on to you. Nor does the Claims Administrator (UHC) apply rebates or other discounts towards your Annual Deductible or Coinsurances.

The Claims Administrator (UHC) and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. The Claims Administrator (UHC) is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

The Claims Administrator (UHC) may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition. It is important to note that if you use a manufacturer coupon or copay card for Specialty Medications, the amount paid by the manufacturer on your behalf will not apply to your deductible or out of pocket maximums. Only your true out of pocket costs will apply to your deductible or out of pocket maximums.

EXCLUSIONS: PRESCRIPTION DRUG PLAN BENEFITS NOT COVERED

The exclusions listed below apply to the **PRESCRIPTION DRUGS** section. In addition, exclusions from coverage listed in the **EXCLUSIONS: PLAN BENEFITS NOT COVERED** section also apply to this section.

When an exclusion applies to only certain Prescription Drugs, you can access myuhc.com through the Internet or by calling the phone number on the back of your ID card for information on which Prescription Drugs are excluded. This listing is subject to change and is updated from time to time and over time.

Medications that are:

1. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers compensation law or other similar laws, whether or not a claim for such Benefits is made or payment or benefits are received;
2. any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or Benefits are received, except as otherwise provided by law;
3. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs

that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;

4. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3;
5. dispensed outside of the United States, except in an Emergency;
6. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
7. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition);
8. the amount dispensed (days supply or quantity limit) which exceeds the supply limit;
9. the amount dispensed (days supply or quantity limit) which is less than the minimum supply limit;
10. certain Prescription Drugs that have not been prescribed by a specialist physician;
11. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
12. certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee;
13. weight loss drugs excluded except those covered by the plan and prescribed by a qualified provider;
14. Prescription Drugs, including new Prescription Drugs or new dosage forms, that UnitedHealthcare determines do not meet the definition of a Covered Health Service;
15. Prescription Drugs that contain an approved biosimilar or a biosimilar and Therapeutically Equivalent (having essentially the same efficacy and adverse effect profile) to another covered Prescription Drug;
16. A Pharmaceutical Product for which Benefits are provided in the medical (not in the Outpatient Prescription Drugs) portion of the Plan;
17. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug;
18. A Pharmaceutical Product for which Benefits are provided in the medical (not in the Outpatient Prescription Drugs) portion of the Plan;
19. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion
20. does not apply to Depo Provera and other injectable drugs used for contraception;
21. in a particular Therapeutic Class (visit myuhc.com or call the number on the back of your ID card for information on which Therapeutic Classes are excluded);
22. unit dose packaging of Prescription Drugs; in certain unit dose packaging or repackagers of Prescription Drug Products.
23. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless the Claims Administrator (UHC) and Lumen have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in the Glossary section;
24. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed. However, Replacement Prescription Drugs are automatically available for catastrophes and natural disasters, such as floods and earthquakes. (***Note:*** *You have the option to appeal if an excluded drug is prescribed for a specific medical condition. Please reference* **CLAIMS PROCEDURES** *for more information.*);
25. used for cosmetic purposes; and
26. vitamins, except for the following which require a prescription:
    - prenatal vitamins;
    - vitamins with fluoride; and

- single entity vitamins.

CLAIMS PROCEDURES

Network Benefits

In general, if you receive Covered Health Services from a Network provider, the Claims Administrator (UHC) will pay the Provider or facility directly.

If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call the Claims Administrator (UHC) at the phone number on your ID card for assistance.

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

Out-of-Network Benefits

If you receive a bill for Covered Health Services from a Out-of-Network provider, you (or the provider if they prefer) must send the bill to the Claims Administrator (UHC) for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the Claims Administrator (UHC) at the address on the back of your ID card. The Claims Administrator (UHC)'s address is also shown in the **CLAIMS ADMINISTRATOR (UHC) AND CONTACT INFORMATION** section.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post- service claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay Coinsurance and you believe that the amount of the Coinsurance was incorrect.
- You paid for a maintenance prescription using a coupon or store discount instead of using the Mail Order pharmacy

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

How To File Your Claim

You can obtain a claim form by visiting myuhc.com or by calling the phone number on the back of your ID card or contacting the Lumen Health and Life Service Center. If you do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

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

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

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

For medical claims, the above information should be filed with the Claims Administrator (UHC) at the address on your ID card. When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

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

The Claims Administrator (UHC) will pay Benefits to you unless:

- the provider notifies the Claims Administrator (UHC) that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the Out-of-Network provider to be paid directly at the time you submit your claim.

The Claims Administrator (UHC) will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider has assigned Benefits to that third party.

Health Statements

Each month in which the Claims Administrator (UHC) processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your familys medical costs by providing claims information in easy-to-understand terms.

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

Explanation of Benefits (EOB)

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

Important – Timely Filing of Out-of-Network Claims

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

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 patients name and ID number as shown on the ID card;
- the providers 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 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.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call the Claims Administrator at the number listed on your health plan ID card. Generally, an urgent situation is when your life or health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your claim or appeal.

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) 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) decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Persons name, address, and insurance ID number;
- your designated representatives 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 requests 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) 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 individuals 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 claimants 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 MEDICAL** 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
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**

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
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 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**
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

Post-Service Claims	
Type of Claim or Appeal	**Timing**
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 Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator (UHC) must notify you within:	**30 days**

Eligibility/Participation Claims	
Type of Claim or Appeal	**Timing**
You must then provide completed claim 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**

Eligibility/Participation Claims	
Type of Claim or Appeal	**Timing**
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 General Counsel:

100 CenturyLink Drive
Monroe, LA 71203

Legal process may also be served on:

CT Corporation System (a.k.a. CT Corporation)
1675 Broadway, Suite 1200
Denver, Colorado 80202

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).

COORDINATION OF BENEFITS (COB)

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

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

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

Remember: Update your Dependents' Medical Coverage Information to avoid delays on your Dependent claims. Just log on to myuhc.com (as identified on the back of your ID card) or call the phone number on the back of your ID card to update your COB information. You will need the name of your Dependent's **other medical coverage, along with the policy number.**

See the *Retiree General Information SPD* for more details regarding Coordination of Benefits.

Special Note Regarding Medicare & Medicaid

Plan's Benefits when you are eligible for Medicare but do not enroll in Medicare. The Claims Administrator will use the Medicare approved amount or Medicare limiting charge as the eligible charge. If you are enrolled in Medicaid and still have coverage under the Lumen group medical plan, the Lumen plan will pay as primary.

Members with Medicaid coverage can continue to use a retail pharmacy for maintenance medications if they call in for an override. Overrides must be obtained by calling the 800# on your ID card each year for each medication.

Coordination with Military Benefits

While you are on a military leave of absence, the military benefits for which you are eligible will be the Primary payor. However, if your Dependents participate under the Plan while you are on military leave, the Plan coverage is primary; and any military coverage for them will be secondary to the Plan. **See the Retiree General Information SPD for more details regarding Military status provisions.**

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans.

The Claims Administrator (UHC) may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under this Plan and other plans covering the person claiming Benefits.

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

Overpayment and Underpayment of Benefits

See the *Retiree General Information SPD* regarding provisions for COB overpayment and underpayments due to multiple plan payments.

RIGHT OF FULL RESTITUTION (SUBROGATION) AND REIMBURSEMENT

The Health Plan does not provide Benefits for any accident, Injury or Sickness for which you or your eligible Dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). This includes, but is not limited to, any claim for damages or entitlement to recover from your or another party's:

- Underinsured and uninsured motorist coverage
- No fault and medical payments coverage
- Other medical coverage
- Worker's compensation
- Short term and long term disability coverage
- Personal injury coverage
- Homeowner's coverage
- Other insurance coverage available

No-fault insurance benefits and auto medical payments coverage should always be selected as the primary coverage if given a choice when purchasing automobile insurance coverage as the Benefits available under this Plan are secondary to automobile no-fault and medical payments coverage.

In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by you or your eligible Dependents when expenses arise from an accident, Injury or Sickness, subject to the terms of the Plan, the Plan may conditionally advance the payment of the Benefits. **If the Plan advances payment of Benefits, 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 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 alleged comparative fault or contributory negligence in causing the injury(ies) or accident for which the Plan advanced medical benefits.**

Benefits Conditional Upon Cooperation

By participating in the Plan, you and your eligible Dependents acknowledge and agree to the terms of the Plan's equitable or other rights to full restitution, reimbursement or any other available remedy. You will take no action to prejudice the Plan's rights to restitution, reimbursement or any other available remedy. You and your eligible Dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator or the Company, including the signing of any documents or agreements necessary for the Plan to obtain full restitution, reimbursement or any other available remedy.

Other Party Liability

If you or your Eligible Dependent is injured or becomes ill due to the act or omission of another person (an "other party"), the Plan Administrator shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement, subrogation or any other available remedy to recover the amounts the Plan Administrator paid for Services provided to you or your Eligible Dependent from any recovery (defined below) obtained by or on behalf of you or your Eligible Dependent, from or on behalf of the third party responsible for the injury or illness or from your coverage, including but not limited to uninsured/underinsured motorist coverage, other medical coverage, no-fault coverage, workers' compensation, STD and LTD coverage, personal injury coverage, homeowner's coverage and any other insurance coverage available.

The Plan Administrator's right to restitution, reimbursement or any other available remedy, is against any recovery you or your Eligible Dependent receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage or other coverages listed above, related to the illness or injury (the "Recovery"), without regard to whether the you or your Eligible Dependent has been "made whole" by the Recovery and without reduction for any attorney fees and costs paid or owed by or on your behalf by you or your Eligible Dependent. You and your eligible Dependents are responsible for all expenses incurred to obtain payment from any other parties, including attorneys' fees and costs or other lien holders, which amounts will not reduce the amount due to the Plan as restitution, reimbursement or any other available remedy.

You or your Eligible Dependent are required to:

1. Notify the Plan Administrator in writing of any actual or potential claim or legal action which such you or your Eligible Dependent expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,
2. Agree to fully cooperate with the Plan Administrator to execute any forms or documents needed to enable the Plan Administrator to enforce its right to restitution, reimbursement or other available remedies; and,
3. Agree to assign to the Plan the right to subrogate and recover Benefits directly from any third party or other insurer. A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable (or other) right to obtain full restitution, reimbursement or any other available remedy.
4. Agree, to reimburse the Plan Administrator for Benefits paid by the Plan Administrator from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage or other coverage; and,
5. Provide the Plan Administrator with a lien in the amount of Benefits actually paid. The lien may be filed with the third party, the third party's agent or attorney, or the court; and,
6. **Notify Cotiviti at 888-556-3373 or fax at 402-384-5190 as soon as possible, that the Plan may have a right to obtain restitution, reimbursement or any other available remedy of any and all Benefits paid by the Plan.** This also means that if you or your Eligible Dependent goes to the Hospital because of an accident, Sickness or Injury that is the result of the actions of another party, you must inform the hospital staff that the Sickness or Injuries are the result of the actions of another for which that other person may be liable. Generally, the hospital staff notes this information on the report that is submitted to the Plan's Claims Administrator. You will later be contacted by the Plan or its recovery vendor and you must provide the information requested. **If you retain legal counsel, your counsel must also contact the Plan or its recovery vendor;** and,
7. Inform the Plan in advance of any settlement proposals advanced or agreed to by another party or another insurer; and
8. Provide the Plan Administrator all information requested by the recovery vendor and the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters from the Plan and its recovery vendor on a timely basis; and
9. Not settle, without the prior written consent of the Plan Administrator, or its designee, any claim that you or your eligible Dependents may have against another party, including an insurance carrier; and
10. Take all other action as may be necessary to protect the interests of the Plan.

In the event you or your eligible Dependents do not comply with the requirements of this section, the Plan may deny Benefits to you or your eligible Dependents or take such other action as the Plan Administrator deems appropriate.

Note: The Plan (Health, Life, Disability, BTA/ADD) is subject to ERISA. Certain plans – specifically, the Health Plan and Disability Plan – are self-funded, and for those plans you and your Eligible Dependent are also required to do the following:

1. Ensure that any Recovery is kept separate from and not comingled with any other funds or you or your Eligible Dependent's general assets (for example, your household checking account) and agree to hold and retain that the portion of any Recovery required to fully satisfy the lien or other right of Recovery of the Plan in trust for the sole benefit of the Plan until such time it is conveyed to the Plan Administrator; and
2. **Direct any legal counsel retained by you or your Eligible Dependent or any other person acting on behalf of you or your Eligible Dependent to hold 100% of the Plan's payment of benefits or the full extent of any payment from any one or combination of any of the sources listed above in trust and without dissipation except for reimbursement to the Plan or its assignee and to comply with and facilitate the reimbursement to the Plan of the monies owed it.**

What Happens to Settlements, Refunds, Rebates, Reversions to the Plan

For purposes of this Plan, any and all reversions, settlements, rebates, dividends, refunds or similar amounts or forms of distribution, of any type whatsoever, paid, provided or in any way attributable to the maintenance of a benefit program under this Plan, including but not limited to any outstanding benefit payments or reimbursements that revert to the Company after remaining uncashed or unclaimed for a period of 12 months,

shall be the sole property of the Company, and no portion of these amounts shall constitute "assets" of the Plan, unless and to the extent otherwise required by applicable law.

GENERAL ADMINISTRATIVE PROVISIONS

Plan Document

This Benefits Summary presents an overview of your Benefits. In the event of any discrepancy between this summary and the official *Plan Document*, the *Plan Document* shall govern.

Records and Information and Your Obligation to Furnish Information

At times, the Plan or the Claims Administrator (UHC) may need information from you. You agree to furnish the Plan and/or the Claims Administrator (UHC) with all information and proofs that are reasonably required regarding any matters pertaining to the Plan including eligibility and Benefits. If you do not provide this information when requested, it may delay or result in the denial of your claim.

By accepting Benefits under the Plan, **you authorize and direct any person or institution that has provided services to you, to furnish the Plan or the Claims Administrator (UHC) with all information or copies of records relating to the services provided to you.** The Plan or the Claims Administrator (UHC) has the right to request this information at any reasonable time as well as other information concerning your eligibility and Benefits.

This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the enrollment form.

The Plan agrees that such information and records will be considered confidential. We and the Claims Administrator (UHC) have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required by law or regulation.

For complete listings of your medical records or billing statements, we recommend that you contact your Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we and the Claims Administrator (UHC) will designate other persons or entities to request records or information from or related to you, and will release those records as necessary. Our designees have the same rights to this information as we have.

During and after the term of the Plan, we and our related entities may use and transfer the information gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

Interpretation of Plan

The Plan Administrator, and to the extent it has delegated to the Claims Administrator (UHC), have sole and exclusive authority and discretion in:

- Interpreting Benefits under the Plan
- Determining the eligibility, rights, and status of all persons under the Plan
- Making factual determinations, finding and determining all facts related to the Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Plan.

The Plan Administrator and to the extent it has delegated to the Claims Administrator (UHC) may delegate this discretionary authority to other persons or entities including Claims Administrator's affiliates that may provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers. In certain circumstances, for purposes of overall cost savings or efficiency, the Plan Administrator, or its authorized delegate, may, in its sole discretion, offer Benefits for services that would not otherwise be Covered Health Services.

The fact that the Plan Administrator does so in any particular case shall not in any way be deemed to require them to do so in other similar cases.

Right to Amend and Right to Adopt Rules of Administration

The Plan Administrator, the Lumen Retiree Benefits Committee, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plans. The Company, in its separate and distinct role as the Plan Sponsor has the right, within its sole discretion and authority, at any time to amend, modify, or eliminate any benefit or provision of the Plans or to not amend the Plans at all, to change contribution levels and/or to terminate the Plans, subject to all applicable laws. The Company has delegated this discretion and authority to amend, modify or terminate the Plan to the Lumen Plan Design Committee.

Clerical Error

If a clerical error or other mistake occurs, however occurring, that error does not create a right to Benefits. Clerical errors include, but are not limited to, providing misinformation on eligibility or benefit coverages or entitlements or relating to information transmittal and/or communications, perfunctory or ministerial in nature, involving claims processing and recordkeeping. Although every effort is and will be made to administer the Plan in a fully accurate manner, any inadvertent error, misstatement or omission will be disregarded and the actual Plan provisions will be controlling. A clerical error will not void coverage to which a Participant is entitled under the terms of the Plan, nor will it continue coverage that should have ended under the terms of the Plan. When an error is found, it will be corrected or adjusted appropriately as soon as practicable. Interest shall not

be payable with respect to a Benefit corrected or adjusted. It is your responsibility to confirm the accuracy of statements made by the Plan or our designees, including the Claims Administrator (UHC), in accordance with the terms of this SPD and other *Plan Document*s.

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 an Eligible Participant wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

Administrative Services

The Plan may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing and utilization management services. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Examination of Covered Persons

In the event of a question or dispute regarding Benefits, the Plan may require that a Physician of the Plan's choice examine you at our expense.

Workers' Compensation Not Affected

Benefits provided under the Health Plan do not substitute for and do not affect any requirements for coverage by Worker's Compensation insurance.

Conformity with Statutes

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations. As a self-funded plan, the Plan generally is not subject to State laws and regulations including, but not limited to, State law benefit mandates.

Incentives to You

Sometimes you may be offered coupons, enhanced Benefits, or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs and/or programs to seek care in a more cost-effective setting and/or from Designated Providers.

In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your medical ID card if you have any questions.

Incentives to Providers

The Plan and the Claims Administrator (UHC) do not provide health care services or supplies, nor does or the Plan Administrator practice medicine.

Rather, the Claims Administrator (UHC) arranges for Providers to participate in a Network. Network Providers are independent practitioners; they are not Employees or Employees of the Claims Administrator (UHC), nor is there any other relationship with Network Providers such as principal-agent or joint venture. Each party is an independent contractor.

The Plan arranges payments to Network Providers through various types of contractual arrangements. These arrangements may include financial incentives by the Plan or the Claims Administrator (UHC) to promote the delivery of health care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to health care. Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness
- Capitation is when a group of Network Providers receives a monthly payment for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the health care is less than or more than the payment
- Risk-sharing payments – the Network provider is paid a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per Covered Person or an amount per service with targeted outcome. If the amount paid is more than the cost of providing or arranging a Covered Person's health services, the Network provider may keep some of the excess. If the amount paid is less than the cost of providing or arranging a Covered Person's health service, the Network provider may bear some of the shortfall
- Various payment methods to pay specific Network Providers are used. From time to time, the payment method may change. If you have questions about whether your Network Provider's contract includes any financial incentives, we encourage you to discuss those questions with your Provider. You may also contact the Claims Administrator (UHC) at the telephone number on your ID card. The Claims Administrator (UHC) can advise whether your Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Services for a particular procedure or medical condition. Your Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Services that are not considered part of the inclusive bundled payment and those Covered Health Services would be subject to the applicable Copayment and/or Coinsurance as described in your Schedule of Benefits.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above.

Refund of Benefit Overpayments

If the Plan pays Benefits for expenses incurred by a Covered Person, that Covered Person, or any other person or organization that was paid, must refund the overpayment if:

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future Benefits including adding the amount of the overpayment to your W-2 income.

Additionally, if the Covered Person was determined not to be eligible for the Benefits under the Plan, that individual must refund the amount of the excess Benefit payment and the Plan may undertake collection actions, subject to the requirements of applicable law.

Your Relationship with the Claims Administrator (UHC) and the Plan

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

- the Plan and the Claims Administrator (UHC) do not decide what care you need or will receive. You and your Physician make those decisions;
- the Claims Administrator (UHC) communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

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

Relationship with Providers

The relationships between the Plan, the Claims Administrator (UHC) and Network providers are solely contractual relationships between independent contractors. Network providers are not Lumens agents or Retirees, nor are they agents or Retirees of the Claims Administrator (UHC). Lumen and any of its Retirees are not agents or Retirees of Network providers, nor are the Claims Administrator (UHC) and any of its Retirees, agents or Retirees of Network providers.

The Plan and the Claims Administrator (UHC) do not provide health care services or supplies, nor do they practice medicine. Instead, The Plan and the Claims Administrator (UHC) arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator (UHC) credentialing process confirms public information about the providers licenses and other credentials but does not assure the quality of the services provided. They are not Lumens Retirees nor are they Retirees of the Claims Administrator (UHC). The Plan and the Claims Administrator (UHC) do not have any other relationship with Network providers such as principal-agent or joint venture. The Plan and the Claims Administrator (UHC) are not liable for any act or omission of any provider.

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

The Plan Administrator is responsible for:

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

Your Relationship with Providers

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

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

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

Do not assume that a Network providers agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some UHC products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Payment of Benefits

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

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

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

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

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

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

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Rebates and Other Payments

Lumen and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physicians office, or at a Hospital or Alternate Facility. Lumen and UnitedHealthcare may pass a portion of these rebates on to you. When rebates are passed on to you, they may be taken into account in determining your Copays and/or Coinsurance.

Review and Determine Benefits in Accordance with UnitedHealthcare Reimbursement Policies

UnitedHealthcare develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UnitedHealthcares reimbursement policies are applied to provider billings. UnitedHealthcare shares its reimbursement policies with Physicians and other providers in UnitedHealthcares Network through UnitedHealthcares provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UnitedHealthcare's reimbursement policies) and the billed charge. However, **Out-of-Network providers are not subject to this prohibition, and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UnitedHealthcares reimbursement policies does not reimburse (in whole or in part) for the service billed.** You may obtain copies of UnitedHealthcares reimbursement policies for yourself or to share with your Out-of-Network Physician or provider by going to myuhc.com or by calling the telephone number on your ID card.

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

GLOSSARY MEDICAL

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout

this SPD, but it does not describe the Benefits provided by the Plan. ***In addition to this Glossary, and throughout this document, there are also terms defined in the Retiree General Information SPD.***

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

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance helicopter or airplane as defined in *42 CFR 414.605*.

Alternate Care Proposals (ACP) – provides appropriate and cost-effective health care services and supply alternatives that would otherwise not be covered by the plan. The Company consents for United Healthcare's use and administration of the ACP program and delegates to United Healthcare the sole discretion and authority to develop and revise ACP's as appropriate.

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

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

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

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

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in the Plan Highlights section. The Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in the Prescription Drugs section.

Annual Enrollment – the period of time, determined by Lumen, during which eligible Retirees may enroll themselves and their eligible Dependents under the Plan. Lumen determines the period of time that is the Annual Enrollment period.

Applied Behavior Analysis (ABA) – a type of intensive behavioral treatment for Autism Spectrum Disorder. ABA treatment is generally focused on the treatment of core deficits of Autism Spectrum Disorder, such as maladaptive and stereotypic behaviors that are posing danger to self, others or property, and impairment in daily functioning.

Assisted Reproductive Technology (ART) – the term for procedures involving the manipulation of human reproductive materials (such as sperm, eggs and/or embryos) to achieve Pregnancy. Examples of such procedures are:

- In vitro fertilization (IVF).
- Gamete intrafallopian transfer (GIFT).
- Pronuclear stage tubal transfer (PROST).
- Tubal embryo transfer (TET).
- Zygote intrafallopian transfer (ZIFT).

Autism Spectrum Disorders – a group of neurobiological disorders that includes *Autistic Disorder, Rhetts Syndrome, Aspergers Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*

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

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a persons weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

CHD – see Congenital Heart Disease (CHD).

Claims Administrator (UHC) – United Healthcare & OptumRx the organization that provide certain claim administration and other services for the Plan. Refer to the Claims Administrator (UHC) and Contact Information Table near the beginning of this SPD.

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

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

Coinsurance – the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services as described in, *How the Plan Works* and *Outpatient Prescription Drugs*.

Company – Lumen Technologies, Inc.

Complications of Pregnancy – a condition suffered by a Dependent child that requires medical treatment before or after Pregnancy ends.

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

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

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

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain Retirees/Retirees and their covered dependents whose group health insurance has been terminated. ***Refer to the Retiree General Information SPD for more information.***

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

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

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms
- Medically Necessary
- Described as a Covered Health Service in this SPD, and
- Provided to a Covered Person who meets the Plan's eligibility requirements.

Covered Person – either the eligible Retiree or an enrolled eligible Dependent as defined by the Plan and only while such person(s) is enrolled and eligible for Benefits under the Plan. References to you and your throughout this SPD are references to a Covered Person. ***See the Retiree General Information SPD for more details.***

CRS – see Cancer Resource Services (CRS).

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

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

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

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described in the *Retiree General Information SPD*. A Dependent does not include anyone who is also enrolled as an Retiree. No one can be a Dependent of more than one Retiree.

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

To be considered a Designated Facility or Centers of Excellence a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described in the *Retiree General Information SPD*.

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

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

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable, other than the diabetic supplies and inhaler spacers specifically stated as covered;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;

- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

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

Eligible Expenses are determined in accordance with UnitedHealthcare's reimbursement policy guidelines or as required by law. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency – a serious medical condition or symptom (including severe pain) resulting from Injury, Sickness or Mental Illness, or substance use disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or jeopardy to life or health, including with respect to a pregnant woman, the health of the woman or her unborn child.

Emergency Health Services – with respect to an Emergency, both of the following:

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3))*.

Employer – Lumen Technologies, Inc.

EOB – see Explanation of Benefits (EOB).

Employer Retirement Income Security Act of 1974 (ERISA) – the federal law that regulates retirement and employee welfare benefits maintained by employers.

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

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

- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the Claims Administrator (UHC) may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator (UHC) must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Alternate Care Proposals (ACP):

- Provides appropriate and cost effective health care services and supply alternatives that would otherwise not be covered by the plan.
- Lumen consents for United Healthcare's use and administration of the ACP program and delegates to United Healthcare the sole discretion and authority to develop and revise ACP's as appropriate.

Explanation of Benefits (EOB) – a statement provided by the Claims Administrator (UHC) to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan

Gender Dysphoria – A disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

Diagnostic criteria for adults and adolescents:

- A marked incongruence between ones experienced/expressed gender and assigned gender, of at least six months duration, as manifested by at least two of the following:
- A marked incongruence between ones experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- A strong desire to be rid of ones primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from ones assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from ones assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from ones assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

Diagnostic criteria for children:

- A marked incongruence between ones experienced/expressed gender and assigned gender, of at least six months duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
- A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from ones assigned gender).

- In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
- A strong preference for cross-gender roles in make-believe play or fantasy play.
- A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
- A strong preference for playmates of the other gender.
- In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
- A strong dislike of ones sexual anatomy.
- A strong desire for the primary and/or secondary sex characteristics that match ones experienced gender.
- The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

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

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable law; and
- Provides Emergency Health Services.

Infertility – A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery. It is defined by the failure to achieve a successful pregnancy after 12 months or more of appropriate, timed unprotected intercourse or Therapeutic Donor Insemination. Earlier evaluation and treatment may be justified based on medical history and physical findings and is warranted after 6 months for women age 35 years or older.

Injury – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment – a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Long-term Acute Care Facility (LTAC) – a facility or hospital that provides care to people with complex medical needs requiring long-term hospital stay in an acute or critical setting.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the programs costs.

Medically Necessary – health care services that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UHCprovider.com

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by Lumen who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator (UHC) or with its

affiliate to participate in the Network.The Claims Administrator (UHC) affiliates are those entities affiliated with the Claims Administrator (UHC) through common ownership or control with the Claims Administrator (UHC) or with the Claims Administrator (UHC) ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a Out-of-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits – description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the **Plan Highlights (CDHP Network and Virtual Networks)** for details about how Network Benefits apply.

New Pharmaceutical Product – a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ends on the earlier of the following dates:

- The date it is reviewed or;
- December 31st of the following calendar year

Non-Medical 24-Hour Withdrawal Management – An organized residential service, including those defined in the American Society of Addiction Medicine (ASAM) Criteria providing 24-hour supervision, observation, and support for patients who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

Out-of-Network Benefits – description of how Benefits are paid for Covered Health Services provided by Out-of-Network providers. Refer to the **Plan Highlights (CDHP Network and Virtual Networks)** for details about how Out-of-Network Benefits apply.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to the **Plan Highlights (CDHP Network and Virtual Networks)** for the Out-of-Pocket Maximum amount. See the **"CDHP PLAN FEATURES AND HOW THE PLAN WORKS"** for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, naturopath or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Lumen Health Care Plan.

Plan Administrator – Lumen Retiree Benefits Committee and its designees..

Plan Sponsor – Lumen Technologies, Inc.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with what is listed.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and

Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Primary Physician.

Prior Authorization – Advanced approval to receive health care services deemed medically necessary by the Claim's Administrator. These are healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, including surgically implanted medical devices that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- if you and/or a covered dependent have had services including medical devices approved in the past by UnitedHealthcare and have had a recent medical condition change which results in an increase of pain, device malfunction (including battery replacement) and/or deteriorating medical condition, the services must be reviewed to determine if they are covered under the plan in order for the device to be repaired or replaced. Recent and sufficient clinical data must be provided in order for coverage to be determined

  Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

  If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

  UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on myuhc.com or by calling the number on the back of your ID card, and to Physicians and other health care professionals on UnitedHealthcare Online.

Private Duty Nursing – nursing care that is provided to a patient on a one-to- one basis by licensed nurses in a home setting when any of the following are true:

- services exceed the scope of Intermittent Care in the home;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Recognized Amount – the amount which Copayment, Coinsurance and applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at certain Network facilities by non-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act*. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on either:

1. An All Payer Model Agreement if adopted,
2. State law, or
3. The lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: Covered Health Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Retiree – meets the eligibility requirements specified in the Plan, as described under Eligibility in the **"INTRODUCTION"** section. An Retiree must live and/or work in the United States. The determination of whether an individual who performs services for the Company is an Retiree of the Company or an independent contractor and the determination of whether an Retiree of the Company was classified as a member of any classification of Retirees shall be made in accordance with the classifications used by the Company, in its sole discretion, and not the treatment of the individual for any purposes under the Code, common law, or any other law.

Residential Treatment Facility – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
  - room and board;
  - evaluation and diagnosis;
  - counseling; and
  - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Semi-private Room – a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Short-term Acute Care Facility – a facility or hospital that provides care to people with medical needs requiring short-term hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden sickness, injury, or flare-up of a chronic sickness.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance use disorder, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician – a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.

Spinal Treatment – the therapeutic application of chiropractic and/or spinal treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in the *Retiree General Information SPD*.

Sub-acute facility – a facility that provides intermediate care on a short-term or long-term basis.

Substance Use Disorder Services – Substance-Related and Addictive Disorders Services – Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the *International Classification of Diseases section on Mental and Behavioral Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate – a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Transitional Living – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision including those defined in the American Society of Addiction Medicine (ASAM) Criteria, that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient

and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

The Claims Administrator (UHC) has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Claims Administrator (UHC) issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at myuhc.com

Please Note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the Claims Administrator (UHC) may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator (UHC) must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.
- The Claims Administrator (UHC) may, in its discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration (FDA)*, it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that the Claims Administrator (UHC) does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow the Claims Administrator (UHC) to conclude that the service is promising but unproven.The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at the Claims Administrator (UHC)'s discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life- threatening but requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Virtual Visit (Telehealth): Virtual visits are Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed virtually through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care Specialist, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are at a location, distinct from a hospital emergency department, an office or a clinic;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and

- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

Virtual Visit (Telehealth) – Virtual visits are Covered Health Services that include the diagnosis and treatment of medical and mental health conditions for Participants that can be appropriately managed virtually through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology, or through federally compliant secure messaging applications with, or supervised by, a licensed and qualified practitioner. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health care Specialist, through use of interactive audio and video communications equipment or through federally compliant secure messaging applications outside of a medical facility (for example, from home or from work).

Well Connected – programs provided by the Claims Administrator (UHC) that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Well Connected Nurse – the primary nurse (Personal Health Nurse) that the Claims Administrator (UHC) may assign to you if you have a chronic or complex health condition. If a Well Connected Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

GLOSSARY – PRESCRIPTION DRUGS

Brand-name – a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by the Claims Administrator (UHC) as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

Note: You should know that all products identified as brand name by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator (UHC).

Designated Pharmacy – a pharmacy that has entered into an agreement with the Claims Administrator (UHC) or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic – a Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by the Claims Administrator (UHC) as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a generic by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator (UHC).

Network Pharmacy – a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator (UHC) to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Claims Administrator (UHC) as a Network Pharmacy.

PDL – see Prescription Drug List (PDL).

PDL Management Committee – see Prescription Drug List (PDL) Management Committee of the Claims Administrator (UHC).

Predominant Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a Out-of-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a Out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax. The Claims Administrator (UHC) calculates the Predominant Reimbursement Rate using its Prescription Drug Charge that applies for that particular Prescription Drug at most Network Pharmacies.

Prescription Drug – a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies: insulin syringes with needles; blood testing strips – glucose; urine testing strips – glucose; ketone testing strips and tablets; lancets and lancet devices; insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and glucose monitors.

Prescription Drug Charge – the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) – a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting the Claims Administrator (UHC) at the phone number on the back of your ID card or by logging onto myuhc.com.

Prescription Drug List (PDL) Management Committee – the committee that the Claims Administrator (UHC) designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Prescription Drug Product – a medication, or product that has been approved by the U.S. Food and Drug Administration (FDA) and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies
  - Standard insulin syringes with needles.
  - Blood-testing strips – glucose.
  - Urine-testing strips – glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Glucose meters including continuous glucose monitors
- Certain vaccines/immunizations administered in a Network Pharmacy.

Preventive Care Medications (PPACA Zero Cost Share) – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following: Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.

With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives through the internet at myuhc.com or by calling UnitedHealthcare at the number on your ID card.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010.

Preventive Medications – a list that identifies certain Prescription Drug Products, on the Prescription Drug List (PDL) that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at myuhc.com or by calling the number on your ID card.

Prior Authorization/Medical Necessity – some non-life threatening prescription drugs require prior approval through the Claims Administrator (UHC) to determine if the drug meets certain criteria or conditions before the drug can be prescribed. Such criteria may include but are not limited to: the medication; dose and duration; lab results; severity of illness, past use of non-drug treatment options; other clinical evidence, and availability of lower cost options. Generally, your physician or pharmacy will initiate this approval.

Specialty Prescription Drug – Prescription Drug that is generally high cost, self- injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. For more information, visit myuhc.com or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutic Class – a group or category of Prescription Drug with similar uses and/or actions.

Therapeutically Equivalent – when Prescription Drugs have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge – the usual fee that a pharmacy charges individual for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

HRA GLOSSARY

Many of the terms used throughout this Section may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. The *HRA Glossary* defines terms used throughout this Section, but it does not describe the benefits provided by the Plan. Capitalized terms not otherwise defined in this section have the meaning set forth in your medical plan SPD.

HRA – Health Reimbursement Account or HRA. It is an IRS Section 105 and 106 account that follows standard regulations and tax benefits for such accounts. It can only be used for qualified medical expenses.

HRA Eligible Expense – an expense that you incur specific to health care on or after the date you are enrolled in the HRA Plan and include the following: (i) an eligible medical expense as defined in Section 213(d); (ii) an Eligible Expense as defined in your medical plan SPD, including Prescription Drugs ; (iii) a medical expense not paid for under your active medical Plan as it represents your portion of responsibility for the cost of health care such as Annual Deductible and Copayments; and (iv) a medical expense not reimbursable through any other plan covering health benefits, other insurance, or any other accident or health plan.