DUKE UNIVERSITY
DURHAM NC

Health Benefit Summary Plan Description
7670-00-140114

Revised 01-01-2025

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

Table of Contents

DUKE UNIVERSITY

GROUP HEALTH BENEFIT PLAN

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependent(s), if any, with summary information on Your benefits along with information on Your rights and obligations under this Plan. We are pleased to provide You with benefits that can help meet Your health care needs.

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

The employer assumes the sole responsibility for funding the Plan benefits out of general assets, however employees help cover some of the costs of covered benefits through contributions, Deductibles, Copays and Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letter, even though it normally would not be capitalized. These terms have special meaning under the Plan and most will be listed in the Glossary of Terms. When reading this document, please refer to the Glossary of Terms. Becoming familiar with the terms defined in the Glossary will help You better understand the provisions of this group health Plan.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), cost sharing, the procedures to be followed in submitting claims for benefits and remedies available for appeal of claims denied are outlined in the following pages of this document. Please read this document carefully and contact Your Human Resources department if You have questions.

If You haven't already received this, You will be receiving an identification card that You should present to the provider when You receive services. This card also has phone numbers on the back of the card so You know who to call if You have questions or problems.

This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan document. It is being furnished to You in accordance with ERISA.

Duke University reserves the right to change the benefits offered under this plan at any time. Duke University reserves the right to terminate this plan at any time.

This document became effective on January 1, 2025.

PLAN INFORMATION

Plan Name	DUKE UNIVERSITY Group Benefit Plan
Name and Address of Employer	DUKE UNIVERSITY 705 BROAD ST PO BOX 90502 DURHAM NC 27708-0502
Name, Address and Phone Number Of Plan Administrator	DUKE UNIVERSITY 705 BROAD ST PO BOX 90502 DURHAM NC 27708-0502 919-684-5600
Named Fiduciary	DUKE UNIVERSITY
Employer Identification Number Assigned by the IRS	56-0532129
Plan Number Assigned by the Plan	525
Type of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type of Administration	The Plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the employer's health benefits plan. It is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Agent for Service of Legal Process	Plan Administrator
Funding of the Plan	Employer and Employee contributions. Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Begins on January 1 and ends on the following December 31.
ERISA and Other Federal Compliance	It is intended that this Plan meet all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

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

Fiduciary Liability

To the extent permitted by law, the Plan Administrator and other parties assuming a fiduciary role shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

SCHEDULE OF BENEFITS

Benefit Plans 001, 002, 004

All health benefits shown on this Schedule of Benefits are subject to the individual lifetime and annual maximums, individual and family Deductibles, Copays, Participation rates, and coinsurance maximums, and are subject to all provisions of this Plan including Medical Necessity and any other benefit determination based on an evaluation of medical facts and covered benefits.

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

SUMMARY OF BENEFITS	PPO PROVIDER (In-Network) Providers Accepting Medicare	NON-PPO PROVIDER (Out-of-Network) Providers Not Accepting Medicare
Annual Deductible per calendar year:		
• Per Person	$0	$650
• Per Family	$0	$1,950
Participation Rate, unless otherwise stated below:		
• Paid by Plan after satisfaction of Deductible	100%	70%
Annual Coinsurance Maximum:		
• Per Person	$0	$4,000
• Per Family	$0	$12,000
Ambulance and Other Medically Necessary Emergency Transportation (ground and air):		
• Paid by Plan	100%	100% (Deductible Waived)
Autism Services:		
• Paid By Plan After Deductible	100%	70%
• Maximum visits per calendar year	20 visits	
Cardiac Rehabilitation (Phase I and II only):		
• Copay	$20	$0
• Paid by Plan after Deductible	100%	70%
• Maximum Benefit per lifetime	$1,500	
Chiropractic Services:		
• Copay	$55	$0
• Paid by Plan after Deductible	100%	70%
• Maximum Benefit per calendar year	$750	
Dental (Accidental Injury):		
• Paid by Plan after Deductible	100%	70%
• Maximum Benefit per calendar year	$750	
Durable Medical Equipment:		
• Paid by Plan after Deductible	90%	90%
Extended Care Facility Benefits such as skilled nursing, convalescent or sub-acute facility:		
• Copay per admission	$250	$250
• Paid by Plan after Deductible	100%	100%
• Maximum Days per calendar year	60 days	
Home Health Care Benefits:		
• Paid by Plan after Deductible	100%	100%
• Maximum visits per calendar year	100 visits	

SUMMARY OF BENEFITS	PPO PROVIDER (In-Network) Providers Accepting Medicare	NON-PPO PROVIDER (Out-of-Network) Providers Not Accepting Medicare
Hospice Care Benefits:		
• Paid by Plan after Deductible	100%	100%
• Maximum visits for bereavement counseling per occurrence	5 visits	
Hospital Services (Including Physician Services While in the Hospital):		
Emergency:		
• Copay per visit (waived if admitted within 24 hours)	$250	
• Paid by Plan	100%	
Urgent Care:		
• Copay per visit	$35	$35
• Paid by Plan	100%	100%
Inpatient (Room and board subject to the payment of semi-private room rate):		
• Paid by Plan after Deductible	100%	70%
• Copay per admission to Duke owned hospitals	$600	N/A
• Copay per admission to all other hospitals	$700	$900
Outpatient (Including Outpatient Physician Charges):		
• Copay for surgery	$250	$0
• Paid by Plan after Deductible	100%	70%
Hospital Services:		
Outpatient Imaging Charges:		
• Copay for MRI, CT and PET scans	$150	$0
• Paid By Plan After Deductible	100%	70%
Outpatient Lab and X-ray Charges:		
• Copay for MRI, CT and PET scans	$150	$0
• Paid by Plan after Deductible	100%	70%
Mental Health and Substance Use Disorder and Chemical Dependency Benefits:		
Inpatient or Partial Hospitalization and Residential Treatment Facilities:		
Paid by Plan after Deductible	100%	70%
Copay per admission to Duke owned hospitals	$600	N/A
Copay per admission to all other hospitals	$700	$900
Outpatient Treatment, Group Therapy and Pharmacological Management:		
• Copay	$20	$0
• Paid by Plan after Deductible	100%	70%

SUMMARY OF BENEFITS	PPO PROVIDER (In-Network) Providers Accepting Medicare	NON-PPO PROVIDER (Out-of-Network) Providers Not Accepting Medicare
Lab, Outpatient Charges and ECT Charges: • Paid by Plan after Deductible	100%	70%
Nutrition Counseling: • Maximum Visits Per Calendar Year • Copay per visit • Paid by Plan after Deductible	6 Visits $20 100% (Deductible Waived)	 $0 70%
Pediatric Hearing Aids (Including Evaluation, Fitting, Adjustments, Supplies, and Ear Molds): To Age 22 • Maximum Hearing Aids Per Hearing-Impaired Ear Every 36 Months • Maximum Per Hearing Aid Every 36 Months • Paid by Plan after Deductible	 1 Hearing Aid $2,500 100%	 70%
Physician Services: **Office Visit:** • Copay per visit for Primary Care Physician • Copay per visit for Specialist • Paid by Plan after Deductible **All Other Office Services On the Same Day:** • Paid by Plan after Deductible	 $20 $55 100% 100%	 $0 $0 70% 70%
Routine Care Benefits, other than Well Baby care, include: Routine physical exams (In and Out-of-network) Routine diagnostic tests, lab and X-rays (such as routine mammograms, pelvic exams, pap test, and prostate exams/tests) (In and Out-of-network) Routine eye exam and glaucoma testing including refraction (In-Network only) • Copay per visit for Primary Care Physician • Copay per visit for Specialist • Paid by Plan after Deductible Routine colonoscopy, sigmoidoscopy and similar routine surgical procedures done for diagnosis or preventive reasons • Paid by Plan after Deductible Immunizations that are administered in an office when no other services are provided and the doctor is not seen (e.g., vaccination only) are covered at 100% in-network. • Paid by Plan	 $20 $55 100% 100% (Deductible Waived) 100% (Deductible Waived)	 $0 $0 70% 70% No Benefit
Telehealth: • Copay per visit for Primary Care Physician • Copay per visit for Specialist • Paid by Plan after Deductible	 $20 $55 100%	 $0 $0 70%

SUMMARY OF BENEFITS	PPO PROVIDER (In-Network) Providers Accepting Medicare	NON-PPO PROVIDER (Out-of-Network) Providers Not Accepting Medicare
Therapy (Outpatient Treatment for Occupational Therapy, Physical Therapy and Speech Therapy:		
• Copay	$20	$0
• Paid by Plan after Deductible	100%	70%
• Maximum visits per calendar year for:		
- Occupational & Physical Therapy	40 visits	
- Speech Therapy	20 visits	
Vision Care Benefits:		
• Copay	$55	No Benefit
• Paid by Plan	100%	
Well Baby Care:		
• Paid by Plan	100%	No Benefit
All Other Covered Expenses:		
• Paid by Plan after Deductible or appropriate Copay	100%	70%

TRANSPLANT BENEFITS SUMMARY Benefit Plans 001, 002, 004		
Transplant Services: Designated and Non-Designated Transplant Facility	**PPO PROVIDER (In-Network)** **Providers Accepting Medicare**	**NON-PPO PROVIDER (Out-of-Network)** **Providers Not Accepting Medicare**
• Paid by Plan after Deductible (Subject to Inpatient Hospital Copay) Or Applicable Copay Or Office Visit Copay	100%	70%

COINSURANCE EXPENSES AND MAXIMUMS

COPAYS

A Copay is the amount that the Covered Person must pay to the provider each time certain services are received. Copays do not apply toward satisfaction of Deductibles or coinsurance Maximums. The Copay and coinsurance Maximum is shown on the Schedule of Benefits.

The office Copay applies to the following benefits, in addition to the Copays listed on the Schedule of Benefits:

- Physician office visits.
- Office surgery.
- Charges for a radiologist.

DEDUCTIBLES

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

Deductible amounts are shown on the Schedule of Benefits. The applicable Deductible must be met before any benefits will be paid under this Plan, unless indicated otherwise.

Only Covered Expenses will count toward meeting the Deductible. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

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

PLAN PARTICIPATION

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

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

ANNUAL COINSURANCE MAXIMUMS

The annual coinsurance Maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual coinsurance Maximum (s).

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

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

- Any charges above the limits specified elsewhere in this SPD.
- Copays and Participation amounts for Prescription products.
- Individual and family Deductibles.
- Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays.

INDIVIDUAL LIFETIME MAXIMUM BENEFIT

All Covered Expenses will count toward the Covered Person's individual medical Lifetime Maximum Benefit that is shown on the Schedule of Benefits. The Individual Lifetime Maximum Benefit of this plan is unlimited.

NO FORGIVENESS OF COINSURANCE EXPENSES

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

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan document. The Plan may request documentation (including but not limited to marriage certificates, divorce decrees, the first two pages of your tax return and birth certificates) from You in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

RETIREMENT

To continue to receive the health insurance plan in retirement, You must meet the following criteria:

At the time of retirement, You must be enrolled under the health Plan as the Covered Person.

- Health insurance may also be continued for Your spouse or Same-Sex Spousal Equivalent and eligible Dependent children who are covered at the time of Your retirement.

- If Your spouse or Same-Sex Spousal Equivalent and/or eligible Dependent children are not enrolled at the time of retirement, they will not be eligible for coverage.

- If you have a marriage that occurs on or after January 1, 2020, you have a one-time opportunity to add your new spouse and any stepchildren you acquire as a result of that marriage within 30 days of the date of marriage.

- If You elect to terminate coverage under this Plan, You may not re-enroll unless You obtained coverage as an active Employee. Coverage as a Spouse is not eligible.

ELIGIBILITY REQUIREMENTS FOR DUKE UNIVERSITY AND MEDICAL CENTER (Company Code 10 in SAP)

You must meet the Rule of 75, which became effective July 1, 1990. It requires that Your age plus years of continuous service with Duke at retirement must be equal to or greater than 75. Thus, an employee or faculty member must have at least ten years of continuous service to retire at 65 and continue Duke health coverage.

ELIGIBILITY REQUIREMENTS FOR DUKE UNIVERSITY (DUHS) (All other company codes)

Employees hired on or after July 1, 2002 are eligible for retiree health coverage if they meet the following criteria:

- Have 15 years of continuous service after age 45 – Retiree pays 100% of the premium.

Employees employed by DUHS prior to July 1, 2002 are eligible for retiree health coverage if they meet one of the following criteria:

- Met the Rule of 75 (your age + years of continuous service = 75) as of July 1, 2002.

- Employee had at least 15 years of continuous service (but did not meet the Rule of 75) as of July 1, 2002, then the employee is grandfathered under the Rule of 75 eligibility provision.

- Employee is at least 60 years of age, with 10 or more years of continuous service (but did not meet the Rule of 75) as of July 1, 2002, they the employee is grandfathered under the Rule of 75 eligibility provision.

All other employees employed by DUHS prior to July 1, 2002 are eligible for retiree health coverage at the time of retirement if they meet one of the following eligibility criteria:

- Have 15 years of continuous service after age 45 – DUHS will pay a portion of the premium.

OR

- Met the Rule of 75 – Retiree pays 100% of the premium.

NOTE: If a faculty or staff member meets the retiree health eligibility requirements and retires (early or normal), the retiree may suspend health or dental coverage and contributions at any time while employed and receiving benefits elsewhere.***** Re-enrollment in the health or dental Plan must occur within 60 days of the termination of other employer sponsored coverage. Proof of continuous coverage through another employer plan will be required. If the individual attempts to re-enroll after this 60-day period, the individual must pay the full premium (including the employer share) retroactive to the termination of the prior employer coverage and up to the time of re-enrollment. Thereafter, the individual shall pay the employee/retiree share.

*****Coverage under another plan available to the individual as a retiree of another employer, through a spouse's retiree health plan, or from service with the military does not count as an employee under another employer sponsored plan.

MEDICARE

The Federal Government provides medical benefits for people age 65 or older through Medicare Part A and Part B. Part A coverage includes payment for Inpatient Hospital expenses; Part B helps to pay for Physician's services, Outpatient Hospital care and other medical services not covered by Part A. Both Part A and B are subject to Deductibles and Copays. Health benefits include and are not in addition to Medicare benefits. Health benefits are reduced by any benefit to which a member is entitled under Medicare, except for employees for whom this Plan is primary over Medicare. Contact the Social Security Administration for Medicare enrollment information.

Early Retirees/Surviving Spouses. A Duke Plan will continue as primary coverage for employees who retire before age 65 and are classified as early retirees. However, retired employees/surviving spouses under age 65 who become eligible for Medicare due to disability are required to enroll in Medicare Part A and Part B and Medicare will become the primary coverage. Duke University will become the secondary coverage and Duke Plus will become the plan for which they are eligible to continue coverage. At age 65, enrollment in Medicare Part A and Part B is mandatory as Medicare becomes Your primary coverage and Duke University is secondary. Early retirees, and their spouses, should contact the Social Security Administration approximately three months before their 65th birthday to begin the Medicare enrollment process. As retirees and/or spouses become eligible for Medicare, Duke must be notified of the "Medicare Beneficiary Identifier (MBI)" on their Medicare Card.

Retirees Age 65. Enrollment in Medicare Part A and Part B is mandatory for retirees or their spouses age 65 or older. As a retiree age 65 or older, Medicare is Your primary coverage and Duke University is secondary. Duke University provides supplemental benefits; however, the member must still meet the Plan's Deductible and make any Copays or coinsurance payments required by the Plan. Retirees may not participate in two Plans. If You are eligible for coverage through another employer, Tricare, or have elected another Medicare supplement, You may not continue with Duke Plus.

Disabled. If You are disabled, under age 65, and have been entitled to Social Security disability benefits for 24 months, You are eligible for Medicare coverage. **You must enroll in Medicare Part A and Part B when first eligible**. Medicare is your primary coverage and Duke University is secondary. If Your spouse is actively at work and You are also covered under Your spouse's health plan, the spouse's plan is primary, Medicare is secondary and Duke University pays last.

End Stage Renal Disease. For members entitled to Medicare solely because they have end stage renal disease, the Plan will be the primary coverage for no fewer than 9 but no more than 30 months, starting with the earlier of (a) the month in which a regular course of dialysis is initiated, or (b) in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.

Coordination with Medicare. Unless prohibited by 42 U.S.C., Section 1395y (b)(1)(A) (pertaining to discrimination against the working aged with respect to entitlement of benefits under group health plans), if You and/or Your spouse are eligible for Medicare, but fail to apply, the Plan will provide supplemental benefits only, i.e., Medicare benefits – Both Part A and B will be taken into account when calculating benefits under the Duke University Plan. You must still make all Copays or coinsurance payments required by the Plan **in addition to paying any costs Medicare would have covered if You had enrolled in Medicare as required**.

Medicare Part D - Prescription Drug Coverage - **NOTE: (Applies to Benefit Plan(s) 001, 002)** The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. You may be able to postpone enrollment in the Medicare Prescription Drug coverage if Your current drug coverage is at least as good as Medicare Prescription Drug coverage. If You decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, You may have to pay an additional monthly penalty if You change Your mind and sign up later. You should have received a Notice telling You whether Your current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage. If You need a copy of this notice, please contact Your Plan Administrator.

Benefits are payable for Medicare Part B and Part D eligible prescriptions and/or diabetic supplies purchased through the retail pharmacy, secondary to Medicare payment. Copays do not apply. These medications, and/or diabetic supplies, should ONLY be covered IF Medicare Part B has paid Primary. Once Medicare Part B and Part D pays primary, Duke University will cover the remaining balance without copay or coinsurance.

An **eligible Dependent** includes:

- Your legal spouse, as defined by the state in which You reside, provided he or she is not covered as a Retiree under this Plan. An eligible Dependent does not include an individual from whom You have obtained a divorce. Documentation on a Covered Person's marital status may be requested at any time by the Plan Administrator.

- Your Same-Sex Spousal Equivalent (SSE), so long as he or she meets the definition of Same-Sex Spousal Equivalent (SSE) as stated in the Glossary of Terms, and the person is not covered as a Retiree under this Plan. When a person no longer meets the definition of Same-Sex Spousal Equivalent (SSE), that person no longer qualifies as Your Dependent.

- A Dependent child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents who meet the eligibility criteria listed below:

  - A natural biological Child;
  - A step Child;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 18 as of the date of such placement;
  - A Child under Your (or Your Spouse's Same-Sex Spousal Equivalent (SSE)) Legal Guardianship as ordered by a court;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order;
  - A foster Child;
  - A Child of a Same-Sex Spousal Equivalent (SSE).
  - A Child of a Retiree/Surviving Spouse/Disabled Subscriber still covered under this Plan.

- Coverage of disabled dependent children:

  In order to continue coverage of a mentally or physically disabled dependent child beyond the 26th birthday, all of the following criteria must be met:

  - The parent must apply for the waiver prior to the child's 26th birthday;
  - The mental or physical disability must be significant and render the child incapable of independent living and self-sustaining employment, and must be supported by medical records;
  - The condition must exist on or prior to the 26th birthday;
  - The parent must remain eligible;
  - The parent must provide annual evidence of continued incapacity;
  - There must not be a break in coverage after the 26th birthday under the parental policy.
  - Coverage remains for as long as a covered parent remains on the Plan. When the covered parent(s) are deceased, COBRA will be offered.

EFFECTIVE DATE OF COVERAGE

Your coverage will begin under Duke University on the first day of the month after:

- Retirement at or after age 65.
- Reaching age 65 after early retirement.
- Upon eligibility for Medicare due to disability.
- Surviving spouse/partner reaching age 65 or eligible for Medicare due to disability.

COVERAGE FOR YOUR DEPENDENT(S)

In order to be covered, your eligible Dependent(s) must have already been covered under this Plan as of January 1, 2012. No future new or additional Dependents are eligible to enroll, with the following exception: If you have a marriage that occurred on or after January 1, 2020, you have a one-time opportunity to add your new spouse and any newly-acquired stepchildren to your coverage within 30 days of the date of the marriage.

TERMINATION

Please see the COBRA section of this SPD for questions regarding coverage continuation.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible; or
- The date You pass away. The Benefits Office must be notified within 30 days of the date of death. If notification is not made within 180 days, premium will only be refunded back to the beginning of the current Plan Year; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan; or
- The effective date of your enrollment under a Medicare C or Medicare Advantage Plan, or another Medicare Supplement.

YOUR DEPENDENT'S COVERAGE

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

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or
- The day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The day of the month in which Your Dependent no longer qualifies as a Same-Sex Spousal Equivalent; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section, or
- The date Dependent coverage is no longer offered under this Plan; or
- The day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible.
- Once your dependent is removed, they may not be re-enrolled in the Plan.

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

- The date You or Your Dependent submits a false claim, including fraud and / or abuse of a prescription drug claim, or are involved in any other form of fraudulent act related to this Plan.

- The day of the month both the retiree and spouse/partner pass away, other Dependent children are eligible for Cobra coverage at this time, including Disabled Dependent children.

- The day of the month in which Your divorce is final.

- The day of the month in which Your Dependent passes away.

HEALTH COVERAGE AND LONG-TERM DISABILITY

Employees participating in a Duke Health Plan at the time of approval for Long Term Disability benefits may continue to participate in a Duke Health Plan while on an active claim with the Duke Long Term Disability Plan with the following qualifications:

- The individual must be participating (in a fully paid-up status) in a Duke Health Plan on their last day worked;
- Premiums must be paid in a timely manner, or deducted from the LTD check. If terminated for non-payment, there is no reinstatement.
- There must not be a break in coverage under the disabled individual's Duke Health Plan;
- No additional family members may be added to the coverage once the individual is approved for Long Term Disability regardless of a qualifying event;
- When a family member is removed from coverage, they may not re-enroll;
- Once eligible for Medicare, the individual must notify Benefits and immediately enroll in Medicare A and B. Those who do not enroll in Medicare B in a timely manner will be responsible for payment of those claims that would have been attributable to Medicare B;
- All persons participating in the Duke Long Term Disability program will be enrolled in the Duke Plus Plan once Medicare becomes primary for them or a family member.
- If the individual dies while on Duke Long Term Disability, health coverage for family members will depend on the eligibility of the deceased individual for retiree health benefits. If the decedent was eligible at the time of death, the covered family members may continue under the survivor benefits. COBRA will be available to those who are not eligible.
- Retiree health eligibility is determined using the date the individual first becomes disabled. Inactive or disabled employees do not continue to accrue service towards retiree health eligibility once they are disabled.

COBRA CONTINUATION OF COVERAGE

Important. Read this entire provision to understand Your COBRA rights and obligations.

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

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

The COBRA Administrator for this Plan is: HealthEquity

INTRODUCTION

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

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

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

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

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

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

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

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

If you are the spouse of an Employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happen:

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

The Dependent children of an Employee become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happen:

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

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

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

COBRA NOTICE PROCEDURES

ABOUT THE NOTICE(S) YOU ARE REQUIRED TO PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and Qualified Beneficiaries have certain obligations to provide written notices to the administrator. You should follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

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

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

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

HealthEquity
Claims Administrator
PO Box 223684
Dallas, TX 75222-3684
(800)-526-2720

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

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

RETIREE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

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

Once You have provided notice of the Qualifying Event, then Your employer will notify the COBRA Administrator within 30 calendar days from that date.

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

MAKING AN ELECTION TO CONTINUE YOUR GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. You will receive a COBRA Election Form that You must complete if You wish to elect to continue Your group health coverage. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

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

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing or via the online portal, if available, in order to continue group health coverage and must make the required payments when due in order to remain covered. If online election is available, You will receive instructions for online election when Your election notice is provided. If You do not choose COBRA continuation coverage within the 60-day election period, Your group health coverage will end on the day of Your Qualifying Event.

PAYMENT OF CLAIMS

No claims will be paid under this Plan for services that You receive on or after the date You lose coverage due to a Qualifying Event. If, however, You decide to elect COBRA continuation coverage, Your group health coverage will be reinstated back to the date You lost coverage, provided that You properly elect COBRA on a timely basis and make the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives Your completed COBRA Election Form and required payment.

PAYMENT FOR CONTINUATION COVERAGE

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

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

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

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however You will receive specific payment information including due dates, when You become eligible for and elect COBRA continuation coverage. Payments postmarked within a 30-day grace period following the due date are considered timely payments.

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

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

YOUR NOTICE OBLIGATIONS WHILE ON COBRA

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

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

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

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

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

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

- The date the COBRA Administrator or the Plan Administrator requests additional information from You. You must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

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

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

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

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

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

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

YOUR RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

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

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

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

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

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (part A, part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in case of a newborn Child being added as a result of a HIPAA Special Enrollment right. A Dependent acquired during COBRA continuation (other than newborns and newly adopted Children) is not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred. You must provide the notice of a second Qualifying Event within a 60-day period that begins to run on the latest of:

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

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

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

EARLY TERMINATION OF COBRA CONTINUATION

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

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

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

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

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

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

- Termination for cause, such as submitting fraudulent claims, including fraud and / or abuse of pharmacy claims.

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

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

DEFINITIONS

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

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

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

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

IF YOU HAVE QUESTIONS

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

The Plan Administrator:
DUKE UNIVERSITY
705 BROAD ST
PO BOX 90502
DURHAM NC 27708-0502
919-684-5600

The COBRA Administrator

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

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

COVERAGE

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

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

USERRA NOTICE AND ELECTION

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

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

PAYMENT

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

EXTENDED COVERAGE RUNS CONCURRENT

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

PROTECTION FROM BALANCE BILLING

This section is to be interpreted in accordance with the No Surprises Act, as amended. Covered health care services that are subject to the No Surprises Act requirements will be reimbursed according to this section. Retiree-only plans are not subject to the Protection from Balance Billing requirements.

Emergency health care services provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

Covered health care services provided at certain network facilities by Out-of-Network Physicians, when not Emergency health care services, will be reimbursed as set forth under Allowed Amounts below. For these covered health care services, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

Air Ambulance Transportation provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

ALLOWED AMOUNTS

For covered health care services that are Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are non-Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians who have not satisfied the notice and consent criteria, or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD. Note: You may receive balance bills for post-stabilization services after an Emergency if Your attending Emergency Physician or treating provider determines that You can travel to an In-Network facility using non-medical or non-Emergency transportation but You choose to stay at the Out-of-Network facility, if the notice and consent requirements have been satisfied and the provider or facility acts in compliance with applicable state laws.

For covered health care services that are air Ambulance Transportation services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Copay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

Allowed amounts are determined in accordance with the claims administrator's reimbursement policy guidelines or as required by law, as described in this SPD.

OUT-OF-NETWORK BENEFITS

When covered health care services are received from an Out-of-Network provider as described below, allowed amounts are determined as follows:

- For non-Emergency covered health care services received at certain network facilities from Out-of-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 with respect to a visit as defined by the Secretary of Health and Human Services (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, You are not responsible, and an Out-of-Network Physician may not bill You, for amounts in excess of Your applicable Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For Emergency health care services provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your applicable Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For air Ambulance Transportation provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your Copay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

After the Plan has issued payment for covered health care services, the Plan may be required to pay the provider an additional amount or discount to resolve and settle the provider’s balance bill.

PROVIDER NETWORK FOR DUKE UNIVERSITY PARTICIPANTS THAT ARE NOT ELIGIBLE FOR MEDICARE

Your coverage provides for the use of a Preferred Provider Organization (PPO). Certain benefits are paid at different levels if the service is not provided by a Participating Provider. The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Expense, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the provider is a Non-Participating Provider, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced Participation level with the Covered Person being responsible for a larger percentage of the total medical expense.

A **Participating Provider** is a person or entity who has entered into a written agreement with the PPO, and has agreed to provide services to covered individuals for the fees negotiated in the provider agreement. The negotiated fee arrangement is followed by the Plan instead of the Reasonable Reimbursement or Usual and Customary requirement.

A **Non-Participating Provider** is a person or entity who has not entered into a written agreement with the PPO and has not agreed to accept the fees that the Plan pays for covered services. A Non-Participating Provider may bill You for additional fees over and above what the Plan pays and charges will be subject to the Plan's limitations.

Note that a facility may have both Participating Providers and Non-Participating Providers at the same location so You will want to review the Provider Directory or ask Your provider if they are a Participating Provider or not. The participation status of providers may change from time to time.

The Preferred Provider Organization is:

Duke University UHC Choice Plus Network

The program for Transplant Services at Designated Transplant Facilities is:

OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK BENEFITS

In addition to services required to be covered as specified under the Protection from Balance Billing section of this SPD, some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with Network benefits, the charges may be subject to Plan limitations. The following exceptions may apply:

- Non-air Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- If an In-Network provider is not available within a 50 mile radius, then charges will be processed In-Network for these services.

LIST OF PARTICIPATING PROVIDERS UNDER THE PREFERRED PROVIDER ORGANIZATION

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

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network.

If You meet the requirements for Continuity of Care under applicable law or Network contract, the In-Network benefit level may continue for certain medical conditions and timeframes despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents generally need to be under a continuing treatment plan by a provider or facility who was a member of the participating Network and:

- Undergoing a course of treatment for a serious and complex condition that is either:
  - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm or
  - A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;
- Undergoing Inpatient or institutional care;
- Scheduled for non-elective surgical care, including necessary postoperative care;
- Pregnant and being treated; or
- Terminally ill and receiving treatment for such Illness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

COVERED MEDICAL BENEFITS

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

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

Not every service that is Medically Necessary is covered under the Plan.

PLEASE NOTE: Although a Physician or other health care provider may perform, prescribe or recommend a service, it does not mean that the service is Medically Necessary and/or covered by the Plan.

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

2. **Allergy Testing and Treatment.**

3. **Alopecia:** Scalp hair prostheses worn for hair loss suffered as a result of chemotherapy.

4. **Ambulance Transportation:**

   - Emergency Ambulance Transportation by a licensed ambulance service (ground or air) to an appropriate Hospital where the required Emergency health care services can be performed.
   - Non-Emergency Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care. Medical evacuation is not covered. Services provided primarily for the convenience of travel of the member or caregiver are not covered.

5. **Anesthetics** and their administration.

6. **Artificial Limbs, Eyes and Larynx** when Medically Necessary for Activities of Daily Living, as a result of an Illness or Injury.

7. **Autism Spectrum Disorders (ASD) Treatment**.

   ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

   Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

   Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

8. **Braces, Supports, Trusses and Casts.**

9. **Breast Reductions** if Medically Necessary.

10. **Cardiac Rehabilitation:** (Refer to Schedule of Benefits for limitations)

    - Phase I, while the Covered Person is an Inpatient.
    - Phase II, while the Covered Person is Outpatient. Services generally begin within 30 days after discharge from the Hospital.

11. **Chiropractic Treatment** by a Qualified chiropractor (Refer to Schedule of Benefits for limitations).

12. **Cleft Palate and Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pregraft palatal expander.

13. **Congenital Heart Disease**: If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at a United Resource Transplant Network (URN) facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.

14. **Contraceptives:** Benefits are payable for contraceptives given in a Physician's office. Depo-Provera injections are covered through the pharmacy benefit.

15. **Cornea Transplants** are payable the same as any other Illness subject to the covered benefits provision of this Plan.

16. **Counseling Services** in connection with pastoral or nutritional counseling for diabetic education.

17. **Crutches** (the lesser of rental or purchase price).

18. **Dental and Oral Surgery:**

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident, excluding implants.
    - Inpatient or Outpatient Hospital charges including professional services for X-ray, lab, and anesthesia while in the Hospital if the Covered Person is a child under five, or is severely disabled, or has a medical condition that requires hospitalization or general anesthesia for dental care treatment.
    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct Accidental Injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitus.
    - Incision of accessory sinuses, salivary glands or ducts.
    - Excision of exostosis of jaws and hard palate.
    - Treatment of cleft palate for Dependent children through age 18.

19. **Diabetes Treatment:** Charges incurred for the treatment of diabetes, diabetic self-management education programs, and the use of an insulin infusion pump or other equipment or supplies for use with insulin pump are paid the same as any other Illness. Diabetic supplies and insulin are covered under Your pharmacy plan.

20. **Durable Medical Equipment:** The lesser of the rental or purchase price of wheelchairs, Hospital-type beds, oxygen equipment (including oxygen) and other Durable Medical Equipment, subject to the following:

    - The equipment is subject to review under the UMR CARE section of this SPD, if applicable; and
    - The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury; and

- The equipment will be provided on a rental basis, however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item; and
- Benefits will be limited to standard models, as determined by the Plan; and
- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medical Necessity due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan; and
- If the equipment is purchased, benefits may be payable for subsequent repairs including batteries or replacement only if required:
  - due to the growth or development of a Dependent child;
  - when Medically Necessary because of a change in the Covered Person's physical condition; or
  - because of deterioration caused from normal wear and tear.

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

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

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

22. **Genetic Testing** (including such procedures as amniocentesis) based on Medical Necessity.

23. **Genetic Testing for Breast and Ovarian Cancer** when it is determined to be medically necessary because the following medical criteria and guidelines below have been met:

    - Individuals who are affected with breast or ovarian cancer and are from families with a high risk of BRCA1 or BRCA2 mutations, or
    - Individuals affected with early-onset (age 45 or younger) breast or ovarian cancer but who do not have a known family history of breast or ovarian cancer, or
    - Unaffected individuals (male or female) from families with a known BRCA1 or BRCA2 mutation, or
    - Unaffected individuals from families with high risk of BRCA1 or BRCA2 mutations based on a family history, where it is not possible to test an affected family member for mutation. This applies to both the general population and to potentially high-risk ethnic populations.

24. **Hearing Deficit (through age 18):**

    - Cochlear implant.
    - Soundtec surgical implant.

25. **Home Health Care Services:** (Refer to Home Health Care section).

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

    - **Assessment:** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care:** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.

- **Outpatient Care:** Provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.
- **Bereavement Counseling:** Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist. The services must be furnished within six months of death.

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

27. **Hospice Care** program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

28. **Hospital Services (includes Inpatient services, Surgical Centers and Birthing Centers):**

- Semi-private and private room and board services:
  - For network charges, this rate is based on the network agreement. Semi-private rate reductions may apply.
  - For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or Negotiated Rate, whichever is applicable.
- Intensive care unit room and board.
- Miscellaneous and ancillary services.
- Blood, blood plasma and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

29. **Hospital Services (Outpatient).**

Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

30. **Injectable Medications.** "Self administered" injectable medications purchased through the pharmacy are covered under this plan only if Medicare Part B has paid Primary. Once Medicare Part B pays primary, the remaining balance will be covered by this Plan.

31. **Laboratory Tests** for covered benefits.

32. **Maternity Benefits** for the Retiree or spouse include:

- Prenatal and postnatal care.
- Hospital room and board.
- Obstetrical fees for routine prenatal care.
- Vaginal delivery or Cesarean section.

- Medically Necessary diagnostic testing (such as ultrasound and amniocentesis).
- Abdominal operation for intrauterine pregnancy or miscarriage.
- Elective abortion.
- Home deliveries.

33. **Mental Health Treatment** (Refer to Mental Health section).

34. **Nursery and Newborn Expenses Including Circumcision** are covered for enrolled Children only.

    If a newborn has an Illness, suffers Injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other Covered Expense if coverage is in effect for the baby.

35. **Nutrition Counseling** for all diagnoses, including obesity as shown in the Schedule of Benefits of this SPD.

36. **Orthognathic, Prognathic and Maxillofacial Surgery** when Medically Necessary for Dependent children under age 18 with congenital anomalies.

37. **Oxygen and its Administration.**

38. **Physician Services** for covered benefits.

39. **Prescription Medication and Product Coverage** (Refer to Prescription Benefit section).

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

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

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

41. **Prophylactic Mastectomies** when medically necessary when two or more of the following criteria have been met:

    - Breast biopsy indicates the patient is at high risk for breast cancer.
    - Immediate family history of breast cancer (mother, sister, daughter).
    - Breast cancer (lobular or intraductal) in the contralateral breast.
    - Severe fibrocystic disease that significantly complicates the reading of mammography studies.
    - Maternal or paternal family history of breast cancer consistent with autosomal dominant inheritance.

42. **Qualifying Clinical Trials** as defined below, including routine patient care costs as defined below Incurred during participation in a Qualifying Clinical Trial for the treatment of:

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

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

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

Routine patient care costs for Qualifying Clinical Trials may include:

- Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

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

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

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - *National Institutes of Health* (NIH), including the *National Cancer Institute* (NCI);
    - *Centers for Disease Control and Prevention* (CDC);
    - *Agency for Healthcare Research and Quality* (AHRQ);
    - *Centers for Medicare and Medicaid Services* (CMS);
    - A cooperative group or center of any of the entities described above or the *Department of Defense* (DOD) or the Veteran's Administration (VA);
    - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
    - The *Department of Veterans Affairs*, the *Department of Defense,* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
        - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
        - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;

- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

43. **Radiation Therapy and Chemotherapy.**

44. **Radiology and Pathology** interpretation charges.

45. **Reconstructive Surgery:**

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

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

47. **Sleep Disorders** if Medically Necessary.

48. **Sleep Studies** if Medically Necessary.

49. **Sterilizations (Voluntary).**

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

51. **Surgery and Assistant Surgeon Services** if determined Medically Necessary by the Plan. For Multiple or Bilateral Procedures during the same operative session, it is customary for the health care provider to reduce their fees for any secondary procedures. In-network claims will be paid according to the network contract. For out-of-network claims, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure, and fifty percent (50%) of the Usual and Customary fee allowance for all secondary procedures. These allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

52. **Telehealth.** Consultations made by a Covered Person to a Physician including behavioral health.

53. **Temporomandibular Joint Disorder (TMJ) Services:** Benefits will be provided for the surgical and non-surgical treatment of TMJ. Surgical treatment is covered the same as any other Illness. Covered services include intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension. TMJ shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly. This does not cover orthodontic services.

54. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. (Refer to Schedule of Benefits for limitations). Services include:

    - **Occupational therapy** by a Qualified occupational therapist.
    - **Physical therapy** by a Qualified physical therapist.
    - **Respiratory therapy** by a Qualified respiratory therapist.
    - **Aquatic therapy** by a Qualified physical therapist.

- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or other types of communication disorders such as categorized language disorder, speech sound disorder, child-onset fluency disorder, and pragmatic communication disorder.

The Plan allows coverage for occupational, physical, or speech therapy for Developmental Delays due to Accidents or Illnesses such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome, and cerebral palsy when performed by a Qualified Provider.

55. **Transplant Services** (Refer to Transplant section).

56. **Well-Baby Care:** Routine well-baby care including routine physical exams, laboratory blood tests and immunizations to age 2.

57. **Wigs, Toupees, Hairpieces** for hair loss due to chemotherapy.

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

HOME HEALTH CARE BENEFITS

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

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

- Home visits that are in lieu of visits to the provider's office, and that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
- Intermittent Nurse Services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietitian.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist (subject to visit limits for those services).
- Medical supplies, infusion therapy prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services. Each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary.

EXCLUSIONS

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

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

TRANSPLANT BENEFITS (Dual Choice)

Refer to the UMR CARE section of this SPD for prior authorization requirements

Your coverage provides a choice for transplant care. Use of a Designated Transplant Facility provides incentives to You and Your covered Dependents. Your coverage does not require that a Designated Transplant Facility be used in order to receive benefits, but it is preferred. Designated Transplant Facilities are facilities that must meet extensive criteria in the areas of patient outcomes to include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

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

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

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include facilities that are listed as participating providers.

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

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T) and ex vivo gene therapy.

BENEFITS

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

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

COVERED EXPENSES

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

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

The Plan will provide donor services at a non-designated facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects or injuries are not covered unless the donor is a Covered Person on the Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/Pancreas.
- Pancreas, which meets the criteria as determined by care management.
- Liver.
- Heart.
- Heart/Lung.
- Lung.
- Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions.
- Small Bowel.

SECOND OPINION

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

TRANSPLANT EXCLUSIONS AT DESIGNATED AND NON-DESIGNATED TRANSPLANT FACILITIES

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

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

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

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

- Transplants considered Experimental, Investigational or unproven.

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

- Autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for the treatment of but not limited to:

    - Wilm's Tumor.
    - Testicular cancer.
    - Brain tumors of any kind (including but not limited to gliomas, astrocytomas, rhabdomyosarcomas, and peripheral neuroectodermal tumors).
    - Sarcomas.
    - Lung cancers.

- Ovarian, uterine and cervical cancer.
- Malignant melanoma and other skin cancer.
- Cancer of the genitourinary tract including but not limited to prostate and bladder cancer.
- Peripheral neuroepithelioma.
- AIDS.
- Gastrointestinal tract cancer including esophagus, gastric, small intestine, colon.
- Cancer of the pancreas.
- Patients with brain metastases.
- Head and neck cancer.
- Sickle cell anemia.
- Immune thrombocytopenic purpura.
- Multiple sclerosis.

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

- Expenses related to the purchase of any organ.

MENTAL HEALTH PROVISION

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

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

(B) **Residential Treatment** means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

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

(D) **Outpatient Therapy Services** are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.
- The Plan will allow 72 hours for the Covered Person and his or her family, when applicable, to comply with the prescribed treatment plan. If non-compliance continues, or if there is evidence that the Covered Person is not motivated towards treatment, continued prior authorization will be denied.
- Pharmacological Medical Case Management (medication management and lab charges) are covered benefits.
- Organic psychotic disorders. Benefits are payable after Medicare payment.

MENTAL HEALTH EXCLUSIONS (In addition to the General Exclusions in this document)

- Treatment, care, accommodations, or supplies that are not considered Medically Necessary or appropriate, as determined by the Plan.
- Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided.

- Services from a Social Worker with a Bachelor's degree only.
- Administrative psychiatric services when these are the only services rendered.
- Bioenergetics therapy.
- Carbon dioxide therapy.
- Chart review.
- Confrontation therapy.
- Consultation with a mental health professional for adjudication of marital, child support and custody cases.
- Crystal healing treatment.
- Cult deprogramming.
- Eating disorder and gambling programs based solely on the 12-step model.
- Educational evaluation and therapy.
- EST (Erhard) or similar motivational services.
- Environmental Ecology treatment.
- Equestrian therapy or other types of horse or animal therapy.
- Examinations or treatments exclusively required as part of legal proceedings if not Medically Necessary.
- Expressive therapies (art, poetry, movement, psychodrama) as separately billed services.
- Guided imagery.
- Hemodialysis for schizophrenia.
- Hyperbaric or normobaric oxygen therapy.
- Internet therapy.
- L-Tryptophan and vitamins, except thiamine injections on admissions for alcoholism or with diagnosis of nutritional deficiency.
- Marathon therapy.
- Megavitamin therapy.
- Narcotherapy with LSD.
- Orthomolecular therapy.
- Prescriptions paid through prescription drug benefits.
- Primal therapy.
- Private duty nursing.
- Private rooms (except when required for injection control).
- Rolfing.
- Sedative action electrostimulation therapy.
- Speech therapy.
- Sensitivity training.
- Sex therapy.
- Supervision of clinical treatment practitioners or team.
- Therapeutic boarding schools.
- Training analysis (Tuitional or Orthodox).
- Transcendental meditation.
- Treatment of sexual addiction, co-dependency, or any other behavior that does not have a most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) diagnosis.
- Vocational assessment/school assessment.
- Wilderness Camp.
- Z therapy.
- Any service or supply listed under General Exclusions of the Medical Plan as described in the Schedule of Benefits.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY PROVISION

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Copays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Covered Expenses are:

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

(B) **Residential Treatment** means a sub-acute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

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

(D) **Outpatient Therapy Services** are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.
- The Plan will allow 72 hours for the Covered Person and his or her family, when applicable, to comply with the prescribed treatment plan. If non-compliance continues, or if there is evidence that the Covered Person is not motivated towards treatment, continued prior authorization will be denied.

SUBSTANCE USE DISORDER EXCLUSIONS (In addition to the General Exclusions in this document)

The Plan will not pay for:

- Treatment, care, accommodations, or supplies considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.
- Inpatient treatment for intoxication without evidence or history of medical complications.
- Administrative psychiatric services when these are the only services rendered.
- Bioenergetics therapy.
- Carbon dioxide therapy.
- Chart review.

- Confrontation therapy.
- Consultation with a mental health professional for adjudication of marital, child support, and custody cases.
- Crystal healing treatment.
- Cult deprogramming.
- Eating disorder and gambling programs based solely on the 12-step model.
- Educational evaluation and therapy.
- EST (Erhard) or similar motivational services.
- Environmental ecology treatment.
- Equestrian therapy or other types of horse or animal therapy.
- Examinations or treatments exclusively required as part of legal proceedings if not Medically Necessary.
- Expressive therapies (art, poetry, movement, psychodrama) as separately billed services.
- Guided imagery.
- Hemodialysis for schizophrenia.
- Hyperbaric or normobaric oxygen therapy.
- Internet therapy.
- L-Tryptophan and vitamins, except thiamine injections on admissions for alcoholism or with diagnosis of nutritional deficiency.
- Marathon therapy.
- Megavitamin therapy.
- Narcotherapy with LSD.
- Orthomolecular therapy.
- Prescriptions paid through prescription drug benefits.
- Primal therapy.
- Private duty nursing.
- Private rooms (except when required for injection control).
- Rolfing.
- Sedative action electrostimulation therapy.
- Speech therapy.
- Sensitivity training.
- Sex therapy.
- Supervision of clinical treatment practitioners or team.
- Telephone therapy.
- Training analysis (Tuitional or Orthodox)
- Transcendental meditation.
- Treatment of sexual addiction, co-dependency, or any other behavior that does not have a most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) diagnosis.
- Vocational assessment/school assessment.
- Wilderness Camp.
- Z therapy.
- Any service or supply listed under General Exclusions of the Medical Plan as described in the Schedule of Benefits.

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

UTILIZATION MANAGEMENT

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

PRIOR AUTHORIZATION / NOTIFICATION REQUIREMENTS

The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. In general, when the Covered Person receives services from a Managed Care UnitedHealthcare Network Provider or facility, the provider or facility is responsible for obtaining the Prior Authorization. However, the Covered Person should ensure that the provider completes all required Prior Authorizations before services are rendered. If the Covered Person is not receiving covered health care services from a Managed Care UnitedHealthcare Network Provider, the Covered Person is responsible for ensuring that any required Prior Authorizations are completed before services are received. In that case, the Covered Person is responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for Medical Necessity review as required by the Plan. In addition to the requirement to notify and obtain Prior Authorization of a service or procedure in advance, all admissions to a facility also require a notification within 24 hours of the admission. If the stay is accessing a Managed Care UnitedHealthcare Network Provider, that facility must provide timely admission Notification (even if advance Notification was provided by the Physician and pre-service coverage approval is on file). If it is not a Managed Care UnitedHealthcare Network Provider the Covered Person is responsible for ensuring the facility completes that Notification.

Special Notes: A Covered Person who could reasonably expect that the absence of immediate, or Emergency, medical attention would jeopardize the life or long-term health of the individual is responsible for ensuring the provider contacts the Utilization Review Organization as soon as possible by phone or fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

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

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

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

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

Managed Care UnitedHealthcare Network Providers are providers participating in any UnitedHealthcare Network product with the exception of Options PPO.

Prior Authorization / Notification is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called "utilization review." Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization at the number on the back of Your ID card or complete a Prior Authorization search at www.umr.com **before a Covered Person receives services for the following**:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over $1,500 or Durable Medical Equipment rentals over $500.
- Prosthetics over $1,000.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Medical Specialty Drug Program. To encourage safe and cost-effective medication use, prior authorization may be required for some specialty drugs. Please visit Specialty Injectable | UMR for a list of Medical Specialty Drugs that may require prior authorization, including Site of Care when applicable (including select gene therapy drugs, orphan drugs, and CAR-T drugs). To request a copy of the Medical Specialty Drug list, call the toll-free number on the back of Your member identification card and the list will be provided free of charge. Prior authorization does not guarantee benefit payment. This Plan may exclude specific drugs on this list from coverage. Refer to the General Exclusions section of this SPD for possible Medical Specialty Drug exclusions.
- Speech therapy.
- Hypnosis, psychological testing and electro shock therapy for Mental Health Disorders, substance use disorder and chemical dependency.
- Temporomandibular Joint Disorder (TMJ).

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

The applicable claim will be denied if You do not call for prior authorization prior to receiving any of the above services. A penalty does not apply towards the Deductible or coinsurance maximum.

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

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions or in a situation of a confirmed cyberattack that could result in a waiver only for a specified period of time.

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

Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case management. Opportunities are identified by using system-integrated, automated, and manual trigger lists during the Prior Authorization review process. Other trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals.

Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review may be conducted upon request or at the Plan's discretion, and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures and a final determination will be made no later than 30 days after the request for review.

CARE PROVISIONS

Complex Condition CARE

Complex Condition CARE is available to all Covered Persons. CARE nurse managers evaluate and coordinate post-hospitalization needs for members who have a high probability of subsequent readmission within 30 days. Participants are identified based on historical claim factors and current admission information, including, but not limited to:

- unplanned readmission within the past 30 days or multiple unplanned admissions within the past 6 months.
- length of stay.
- complex diagnoses or comorbidities pertaining to, but not limited to, cancer, cardiovascular conditions, kidney failure, pulmonary conditions or infections, End Stage Renal Disease (ESRD), or liver/pancreas/gastrointestinal surgery.
- management of catastrophic and complex behavioral health and substance use disorders and support for identified members utilizing Inpatient/rehabilitation/residential facilities.

COORDINATION OF BENEFITS

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

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

This applies to the Covered Persons not on Medicare.
The Order of Benefit Determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. If the covered benefit under this Plan is less than or equal to the Primary Plan's payment, then no payment is made by this Plan.

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

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual automobile policies. See order of benefit determination rules and General Exclusions: No-Fault State for details (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. This does not include Medicaid.
- This Plan does not, however, coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan.

ORDER OF BENEFIT DETERMINATION RULES

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

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

- When medical payments are available under motor vehicle insurance (including No-Fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier. See General Exclusions – No-Fault State in this SPD for more details.

- The plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan. Employee plan beneficiaries do not include COBRA Qualified Beneficiaries or retirees.

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

- If an individual is covered under a spouse's plan and also under their parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

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

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

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

  - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary.

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

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

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary.

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

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

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

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

MEDICARE

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

This applies to the Covered Persons not on Medicare.
The Order of Benefit Determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. If the covered benefit under this Plan is less than or equal to the Primary Plan's payment, then no payment is made by this Plan.

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

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

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

- This Plan generally has primary responsibility to pay claims before Medicare under the following circumstances:
  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first (has primary responsibility) under the following circumstances:
  - You are no longer actively employed by an employer; and
  - You or Your spouse has Medicare coverage due to Your age, plus You also have COBRA continuation coverage through the Plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with End-Stage Renal Disease until the end of the 30-month period; or
  - You or Your covered spouse have coverage under a retiree plan plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).

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

TRICARE

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

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

RIGHT OF RECOVERY

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

RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, Your representative(s), Your Dependents, and Your beneficiaries unless otherwise stated.

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

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

The following persons and entities are considered third parties:

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

You agree as follows:

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

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

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

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

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

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

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

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

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

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

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

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.

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

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

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

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

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

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

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

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

- In the case of occupational Illness or Injury, the Plan's recovery rights will apply to all sums recovered, regardless of whether the Illness or Injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise Workers' Compensation settlement, including any lump-sum settlement, will be deemed to include the Plan's interest and the Plan will be reimbursed in first priority from any such award or settlement.

GENERAL EXCLUSIONS

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

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below or as otherwise required to be covered by the No Surprises Act. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence.

1. **Abortions** for Dependent children unless a Physician states in writing that:

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

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

3. **Acupuncture Treatment**, naturopathy, homeopathy, rolfing, hypnotherapy, massage therapy, aromatherapy, art therapy, hydrotherapy, Equestrian therapy (hippotherapy), pet therapy and similar services.

4. **Alopecia:** Scalp hair prostheses worn for hair loss suffered as a result of alopecia, unless covered elsewhere in this document.

5. **Alternative / Complementary Treatment.** Refer to the Glossary of Terms for a definition of Alternative / Complementary Treatment.

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

7. **Aquatic Therapy** unless provided by a Qualified physical therapist.

8. **Assistance with Activities of Daily Living.**

9. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.

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

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

12. **Blood:** Blood donor expenses, any blood storage, freezing or replacement costs (including umbilical cord blood), or the cost of directed transfusions or autologous blood transfusions not related to a planned, scheduled procedure.

13. **Braces** and supports needed primarily for athletic participation or employment.

14. **Cardiac Rehabilitation** beyond Phase II.

15. **Charges** for services incurred more than 180 days prior to submission of a claim to the Plan.

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

17. **Close Relative:** See Glossary of Terms of this SPD for definition of Close Relative, unless eligible for and enrolled as a spouse or dependent on this plan.

18. **Cognitive Rehabilitation.**

19. **Conditions Listed** in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) in the following categories:

    - personality disorders;
    - behavior and impulse control disorders; or
    - "V" codes.

20. **Cosmetic Treatment**, **Cosmetic Surgery**, or any portion thereof including complications from cosmetic treatment, unless the procedure is otherwise listed as a covered benefit.

21. **Counseling Services** in connection with marriage or financial counseling.

22. **Court-Ordered:** Any treatment or therapy which is court ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of Driving While Intoxicated classes or other classes ordered by the court.

23. **Cranial Band or Cranial Molding Helmets.**

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

25. **Custodial Care.**

26. **Dental,** unless covered elsewhere in this SPD.

27. **Disorders:** Rehabilitation services related to mental retardation or behavioral therapy. Care for senile deterioration, persistent vegetative state, mental retardation, mental deficiency, or any other persistent Illness, disorder or condition that the Plan determines cannot be significantly relieved or improved by medical treatment. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

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

29. **Education:** Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes. This exclusion does not apply to the educational component of a clinical treatment plan that requires clinical educational services provided by a licensed or registered health care professional when there is a lack of knowledge on self-management of the disease.

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

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

32. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes; or sports or recreational activity.

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

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

34. **Eye Diseases:** Protective lenses following a cataract operation, eyeglasses, contact lenses, and any other items or services for the correction of your eyesight, including orthoptics, vision training, vision therapy and radial keratotomy or keratoplasty.

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

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

37. **Foot Care:** Routine foot care and removal of corns, calluses, toenails or subcutaneous tissue, except when care is prescribed by a Physician treating metabolic or peripheral vascular disease.

38. **Foreign Travel:** Foreign travel immunizations.

39. **Gastric Bypass Surgery.**

40. **Genetic Counseling.**

41. **Habilitative Services** including vocational or industrial rehabilitation services or work hardening.

42. **Hearing Services:** The purchase or fitting of hearing aids unless covered elsewhere in this SPD.

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

44. **Hypnotism.**

45. **Infertility Treatment** and direct attempts to achieve pregnancy by any means. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

46. **Inoculations** and physicals for travel outside the United States or for employment, sports or extracurricular activities.

47. **Inpatient** or Outpatient Custodial Care and intermediate care for Alzheimer's disease, senile deterioration, persistent vegetative state, mental retardation, mental deficiency, or any similar persistent Illness or disorder. Custodial care is care that:

    - Primarily helps with or supports daily living activities (such as bathing, dressing, eating and eliminating body wastes); or
    - Can be given by people other than trained medical personnel.

    Care can be custodial even if it is prescribed by a Physician or given by trained medical personnel, and even if it involves artificial methods such as feeding tubes or catheters.

48. **Interest and Legal Fees.**

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

50. **Lasik Surgery** or similar surgery used to improve eye sight.

51. **Learning Disability:** Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other habilitation (such as therapies)/rehabilitation treatment for the primary diagnosis of a Learning Disability. If another medical or behavioral/mental health condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

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

53. **Mammoplasty or Augmentation** unless covered elsewhere in this document.

54. **Massage Therapy.**

55. **Maternity Costs** for Covered Persons other than the employee or spouse.

56. **Medical** evacuation and repatriation of remains.

57. **Military:** A military related Illness or Injury to a Covered Person on active military duty.

58. **Modifications** to home or motor vehicles or special equipment for motor vehicles.

59. **Nicotine**: Services, treatment or supplies related to addiction to or dependency on nicotine.

60. **No-Fault State**: Benefits are not payable under this Plan for any Illness/Injury received in an Accident involving a car or other motor vehicle for participants who are residents of a no-fault state and eligible for benefits under the no-fault motor vehicle law, until such time as the benefits under No-fault have been exhausted.

61. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards.

62. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary.

63. **Nursery and Newborn Expenses** for grandchildren of covered employee or spouse.

64. **Nutrition Counseling,** unless covered elsewhere in this SPD. This exclusion does not apply to preventive care for which benefits are provided under the United States Preventive Task Force requirement. This exclusion also does not apply to medical or behavioral/mental health-related nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

    - Nutritional education is required for a disease in which patient self-management is part of treatment.
    - There is a lack of knowledge regarding the disease resulting in the need for help from a trained professional.

65. **Orthotic Appliances, Devices and Shoe Inserts**, or exam for the prescription or fitting thereof.

66. **Over-the-Counter Medication**, products or supplies.

67. **Penalties** if required pre-authorization is not obtained.

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

69. **Prescription Medication**, other than those administered while in the Hospital or Physician's office as part of treatment, unless benefits are provided under the Prescription Benefit provision of this Plan.

70. **Primary** payment for any condition, disease, ailment, Injury or diagnostic service to the extent that such benefits are covered under, or eligible for coverage under, Title XVIII of the Social Security Act of 1965 including amendments (Medicare) as primary payor, except as otherwise provided by federal law.

71. **Private Duty Nursing Services.**

72. **Radial Keratotomy or Refractive Keratoplasty:** Radial keratotomy and other refractive keratoplasty procedures.

73. **Reimbursement** for losses or damage caused by theft, negligence, acts of nature, or any other reasons.

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

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

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

77. **Self-Administered Services** or procedures, including self-administered or self-infused medications, that can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (as determined by the claims administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an Outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to members for self-infusion.

78. **Services At No Cost:** Any services or items for which You have no legal obligation to pay, or for which no charge would ordinarily be made. Examples of this include care for conditions related to Your military services, care while You are in the custody of any government authority, and any care that is required by law to be provided in a public facility.

79. **Services** prescribed by or directed by a provider for himself/herself or his/her immediate family.

80. **Sex Therapy.**

81. **Sexual Function:** Any medications, oral or other, used to increase sexual function or satisfaction or penile pumps and erectaid devices, except penile implant for organic disease.

82. **Supplements/Food Substitutes and Replacements:** All enteral feedings, supplemental feedings, over-the-counter nutritional and electrolyte supplements and related supplies including feeding tubes, pumps, bags and products.

83. **Surrogate Motherhood Expenses** or egg/sperm donor expenses.

84. **Take Home Disposable or Consumable Outpatient Supplies**, such as sheaths, bags, elastic garments and bandages, syringes, needles, blood or urine testing supplies, home testing kits, vitamins, dietary supplements and replacements, and special food items, unless they are specified as covered.

85. **Take Home Drugs** furnished by a hospital or non-hospital facility.

86. **Taxes:** Sales taxes, shipping and handling.

87. **Telehealth.** Consultations made by a Covered Person's treating Physician to another Physician.

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

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

90. **Travel:** Travel costs, unless covered elsewhere in this SPD.

91. **Treatments and Evaluations** required by employers, insurers, camps, courts, licensing authorities and other third parties; Physician consultations and special medical reports not directly related to treatment; or appearances by a provider at court hearings and other legal proceedings.

92. **Usual and Customary Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge or the negotiated fee.

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

94. **Vision Care** unless covered elsewhere in this document, except for the annual exam listed in the Summary of Benefits.

95. **Vocational Testing, Evaluation and Counseling:** Vocational and educational services rendered primarily for training or education purposes.

96. **Warning Devices:** Warning devices, stethoscope, blood pressure cuffs or other types of apparatus used for diagnosis or monitoring.

97. **Weight Control:** Treatment, services or surgery for weight control or obesity**,** whether or not prescribed by a Physician or associated with an Illness including Morbid Obesity.

98. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving**, or any similar item for replacement of hair except when due to chemotherapy.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the provider is a Non-Participating Provider, the Covered Person still has the right and privilege to utilize such provider at the Plan's reduced Participation level, with the Covered Person being responsible for a larger percentage of the total medical expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claims determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals. UMR will normally send payment for Covered Expenses directly to the Covered Person's provider.

TYPE OF CLAIMS AND DEFINITIONS

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

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

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

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

PERSONAL REPRESENTATIVE

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

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

PROCEDURES FOR SUBMITTING CLAIMS

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

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

PROOF OF LOSS / CLAIM FILING LIMIT

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 180 days from the date of service. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the proof of loss period will not be allowed.

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

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

HOW HEALTH BENEFITS ARE CALCULATED

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

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or the Protection from Balance Billing allowed amount, or based on the Usual and Customary amounts, minus any Deductible, Plan Participation rate, Copay, or penalties that the Covered Person is responsible for paying. Refer to the Protection from Balance Billing section of this SPD for covered benefits that are payable in accordance with the Protection from Balance Billing allowed amount.

Fee Schedule: Providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Copay or penalties that the Covered Person is responsible for paying.

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

Reimbursement for covered services received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials; or
- Current publicly available data reflecting the costs for health care providers providing the same or similar services, treatment, or materials adjusted for geographical differences plus a margin factor.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your claims administrator or amounts permitted by law. Refer to the Protection from Balance Billing section of this SPD for more information. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Copays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

PRIOR AUTHORIZATION OF BENEFIT DETERMINATION

Each time a claim is submitted by a Covered Person or a provider on behalf of a Covered Person, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, please feel free to call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

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

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the treatment authorization ending or being reduced.

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

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your eligibility.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to have required services Certified before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay contributions if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Protection from Balance Billing allowed amount, the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.

- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

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

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

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

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

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

- Covered Persons must file the appeal within 180 days of the date they received the Explanation of Benefits (EOB) form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the written EOB form seven days after the Plan mailed the EOB form.
- Covered Persons or their Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.

- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

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

- Covered Persons who are not satisfied with the decision following the first appeal, have the right to appeal the denial a second time.
- Covered Persons or their Personal Representative must submit a written request for a second review within 60 calendar days following the date they received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal seven days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no affect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Personal Representative) or other details, please contact the Plan. Refer to the ERISA Statement of Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under section 502(a) of ERISA.

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

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

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

TIME PERIODS FOR MAKING DECISION ON APPEALS

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

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

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

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, Covered Persons have the right to further appeal Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section of this SPD for more details. No such action may be filed against the Plan after three years from the date the Plan gives the Covered Person a final determination on their appeal.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the employer determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

RIGHT TO EXTERNAL REVIEW

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

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
  - Whether a claim for items and services was furnished by a non-network provider at a network facility;
  - Whether an individual gave informed consent to waive the protections under the No Surprises Act;
  - Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
  - Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or
- Other requirements of applicable law.

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

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR nor Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

Notice of the right to external review for Pre-Service appeals should be sent to:

UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Alternatively, You may fax Your request to 888-615-6584, ATTN: UMR Appeals

Notice of the right to external review for Post-Service appeals should be sent to:

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

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

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

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

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

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

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

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

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the claims administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan; this also applies to the plan's prescription drug benefit. These actions, as well as submission of false information, will result in denial of the Covered Person's claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. The Plan will pursue all appropriate legal remedies in the event of fraud.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT

If an employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with the employer's Human Resource policy on family and medical leaves of absence, as if the employee was actively at work if the following conditions are met:

(A) Contribution is paid; and

(B) The employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

(A) The leave period required by the Federal Family and Medical Leave Act of 1993 and any amendment; or

(B) The leave period required by applicable state law.

If coverage is not continued during a family or medical leave of absence, when the employee becomes actively at work, no new Waiting Period will apply.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

(A) The name and last known mailing address of the participant;

(B) The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);

(C) A reasonable description of the type of coverage to be provided to the child or the manner in which such coverage is to be determined; and

(D) The period to which the order applies.

Please contact the Plan Administrator if You would like a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Coverage of Dependent children in cases of adoption or Placement for Adoption as required by ERISA.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Nondiscrimination Act (GINA).

STATEMENT OF ERISA RIGHTS

Covered Persons under this group health Plan, are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as at work sites) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated SPD. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report (Form 5500 series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a COBRA Qualifying Event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "Fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS' RIGHTS

If a claim for a benefit is denied or ignored, in whole or in part, Covered Persons have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If there are any questions about this Plan, the Plan Administrator should be contacted. For any questions about this statement or about a Covered Person's rights under ERISA, or for assistance in obtaining documents from the Plan Administrator, Covered Persons should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely, however the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. The Plan Administrator will provide written notice to Plan participants within 60 days following the adopted formal action that makes material changes to the Plan.

YOUR RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, Your rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not You have received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses incurred before You receive notice of termination.

The Plan will assume that You received the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to You regarding the changes.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Plan assets will be held for the exclusive purpose of providing benefits and defraying reasonable expenses, and will not inure to the benefit of the employer, except:

- If Plan assets consist of both participant contributions and employer contributions, the employer will determine which portion of the remaining assets is from the employer contributions and which portion is from participant contributions. The assets that are from participant contributions will be used to cover the cost of incurred Covered Expenses and reasonable expenses to administer the Plan. The portion of assets that are from employer contributions can be reverted to the employer.
- If all Plan assets are from employer contributions, the assets at the time of termination can revert to the employer, once incurred Plan expenses have been paid.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between You and the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event.

Activities Of Daily Living (ADL) means the following, with or without assistance: Bathing, dressing, toileting and associated personal hygiene; transferring (which is to move in and out of a bed, chair, wheelchair, tub or shower); mobility, eating (which is getting nourishment into the body by any means other than intravenous), and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

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

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic or therapeutic services.

Alternative / Complementary Treatment means:

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Massage therapy;
- Rolfing;
- Wilderness, adventure, camping, outdoor or other similar programs; or
- Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health.

Ambulance Transportation means professional ground or air Ambulance Transportation provided:

- In an Emergency situation; or
- When deemed Medically Necessary, which is to the closest facility most able to provide the specialized treatment required; and the most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Refer to the Protection from Balance Billing section of this SPD for the No Surprises Act requirements specific to air ambulance.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a Certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or Certified nurse midwives.

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step-parents, step-grandparents, siblings, step-siblings, half siblings, children, step-children and grandchildren.

Copay is the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons. Cosmetic or other reconstructive procedures (including any related prostheses) that are not Medically Necessary and complications resulting from such procedures are excluded from this Plan. Cosmetic Surgery means surgery to change the texture or appearance of the skin or the relative size or position of any part of the body when such surgery is not needed to correct or substantially improve a bodily function. Removal of skin lesions is considered cosmetic unless the lesions interfere with normal body functions or malignancy is suspected. Among the procedures the Plan does not cover are: removing or altering sagging skin; any procedure that does not repair a functional disorder; changing the appearance of any part of your body (such as enlargement, reduction or implantation); hair transplants or removal; peeling or abrasion of the skin; Renova® or any other cosmetic drug or treatment; and any procedure that is primarily intended to improve Your physical appearance, whether for emotional, psychological or any other reasons.

Covered Expenses means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of this SPD.

Covered Person means an Employee or Dependent who is enrolled under this Plan.

Custodial Care means nonmedical care given to a Covered Person to assist primarily with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the individual and family Deductible and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Disorder is characterized by severe and pervasive impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Disorders generally do not have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental Illness or other neurological symptoms.

Durable Medical Equipment is equipment which is designed for repeated use; is intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Effective Date means the first day of coverage as defined in this document.

Emergency means a serious medical condition which arises suddenly and requires immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins, which is the first day of the month.
- In the case of marriage, the Enrollment Date is the date of marriage; or the first day of the month following.
- In the case of a Dependent’s birth, the Enrollment Date is the date of such birth.
- In the case of a Dependent’s adoption, the Enrollment Date is the date of such adoption or Placement for Adoption.

Expense Incurred means the charge for a service, treatment, supply or facility. The expense is considered to be incurred on the date the service or treatment is given, the supply is received or the facility is used.

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or sub-acute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

Habilitative Services means services which are educational in scope and purpose and are rendered to develop, improve or accelerate functions that have never been present or are not present to the normal degree of a person of like age or sex.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, Nurse Services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician which is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is Certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician, physical or occupational therapist; home health aide services; pharmacy services and Durable Medical Equipment.

Hospital means:

- A facility that is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency; or, if outside of the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term "Illness" when used in connection with a newborn Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to: Fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs or semen.

Injury means an act causing harm or damage to the body.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation and mathematical reasoning. Specific learning disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling and level of intelligence.

Legal Guardianship/Guardian means the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Lifetime Maximum Benefit means the maximum amount of covered benefits payable while a person is covered under this Plan. When the Lifetime Maximum Benefit is met, a Covered Person is no longer eligible for benefits under this Plan. Lifetime does not mean during the lifetime of the Covered Person.

Maximum Benefit means the maximum amount to be paid by the Plan on behalf of the Covered Person for Covered Expenses which are incurred while the person is covered under the Plan.

Medical Specialty Medications (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms.
- Clinical factors used when reviewing Medical Necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of specialty drugs, and any applicable prior authorization requirements.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.
UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on Your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Mental Health Disorder means any disease or condition within the mental health or psychiatric diagnostic categories 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 the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a covered benefit.

Mentally Disabled means an individual who has been diagnosed to have a psychiatric or behavior disorder that severely limits the individual's ability to function without daily supervision or assistance.

Morbid Obesity means a condition in which an individual 18 years of age or older has a Body Mass Index (BMI) of 40 or more, or 35 or more if experiencing health conditions directly related to his or her weight, such as high blood pressure, diabetes, sleep apnea, etc.

Ordinary Care means the degree of care, skill and diligence that a reasonable and prudent administrator would exercise in making a fair determination on a claim for benefits similar to the claim involved.

Orthotic Appliances means braces, splints and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits after You pay the Deductible(s).

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), or a physician's assistant (PA) or a Certified nurse midwife (CNM).

Placed for or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's placement with the person terminates upon the termination of such legal obligation.

Plan means DUKE UNIVERSITY Group Health Benefit Plan.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventative / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (e.g., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology or mental health/substance use disorder providers. Generally, they provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners give routine medical care; internist treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Provider Directory means a list of the Participating Providers.

Qualified means licensed, registered or Certified by the state in which the provider practices.

Recognized Amount means, in the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Copays, Plan Participation, and applicable Deductibles are based 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, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 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 of Health and Human Services.

The amount is based on either:

- an All Payer Model Agreement if adopted,
- state law, or
- 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 was determined based upon a Covered Expense.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, Accident or Illness. It is generally performed to achieve a normal appearance and may also be performed to improve or restore function.

Retired Employee means a person who was employed full time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

Same-Sex Spousal Equivalent (SSSE) means: An unmarried person of the same sex with whom the covered employee shares a committed relationship, is jointly responsible for the other's welfare and financial obligations, is at least 18 years of age, is not related by blood and is not married or legally separated from anyone else. A Same-Sex Spousal Equivalent Certification is required to be completed and filed with the Plan at the time enrollment of the Same-Sex Spousal Equivalent is requested.

For Your Same-Sex Spousal Equivalent to qualify as a Dependent, You and Your partner must have completed an affidavit in the office of the Plan administrator at 705 Broad St, Durham, NC 27705 prior to January 1, 2016.

Site of Care means the treatment location where services are rendered, for example, Outpatient Hospital, community office, ambulatory infusion site, or home-based settings.

Specialist means a Physician, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians that are not considered Specialists include, but are not limited to, family practitioners, non-specializing internists, pediatricians, obstetricians/gynecologists, and mental health/substance use disorder treatment providers.

Surgical Center means a licensed facility that is: Under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- Provides drug services as needed for medical operations and procedures performed;
- Provides for the physical and emotional well being of the patients;
- Provides Emergency services;
- Has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) is a service provider hired by the Plan to process medical claims, provide medical management or perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan. The Third Party Administrator for this Plan is UMR.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability, conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) in the following categories:

    - Personality disorders, or
    - Sexual/gender identity disorders, or
    - Behavior and impulse control disorders, or
    - "V" codes.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

Waiting Period means the period of time that must pass before coverage can become effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan.

You, Your means the Retiree/Surviving Spouse/Disabled Subscriber.

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY COVERAGE

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These modifications have or will become effective as required by applicable provisions of the Privacy and Security Regulations.

First, under HIPAA Privacy Regulations, this Plan has been modified to allow the Disclosure of Protected Health Information (PHI), as defined under HIPAA, to the Plan Sponsor. The USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section of this document specifies the terms under which the Plan may share PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of Your PHI.

This Plan agrees that it will only Disclose Your PHI to the Plan Sponsor upon receipt of a Certification from the Plan Sponsor that the terms contained in the USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section have been adopted and the Plan Sponsor agrees to abide by these terms.

The HIPAA Privacy Regulation provision of this Plan took effect April 14, 2003.

Second, under HIPAA Security Regulations, this Plan has been modified to require the Plan Sponsor to reasonably and appropriately safeguard Electronic Protected Health Information (Electronic PHI), as defined under HIPAA, created, received, maintained or transmitted to or by the Plan Sponsor on behalf of this Plan.

Modifications made for the HIPAA Security Regulations are effective as of April 21, 2005 and can be identified in this Provision by reference to Security Regulations or Electronic PHI.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use Your Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose Your PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose Your PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share Your PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of Your PHI.

This Plan shall Disclose Your PHI to the Plan Sponsor only to the extent necessary for the purposes of the Administrative Functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose Your PHI only to the extent necessary for the Administrative Functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose Your PHI to the Plan Sponsor upon receipt of a Certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of Your PHI:

- The Plan Sponsor will only Use and Disclose Your PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. Your Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide Your PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to Your PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow You or this Plan to inspect and copy any PHI about You contained in the Designated Record Set that is in the Plan Sponsor’s custody or control. The HIPAA Privacy Regulations set forth the rules that You and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of Your PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. You have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of Your PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all Your PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs Your PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that Your PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of Your PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to Your PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Staff of Duke HR-Benefits and Human Resources Information Center

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive Your PHI. If any of these Employees or workforce members Use or Disclose Your PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to You.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;

- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means Your employer.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

If you have any questions or concerns regarding your eligibility, please call the Group Services Unit – 1-866-318-DUKE (3853).

If you have any questions or concerns regarding your claims, please call your Claim Service Representative – 1-866-318-DUKE (3853).