ARCHDIOCESE OF DENVER WELFARE BENEFITS TRUST

Self-Funded Medical Booklet

Effective July 1, 2024

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

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ARCHDIOCESE OF DENVER WELFARE BENEFITS TRUST

SELF FUNDED MEDICAL PLAN DOCUMENT

INTRODUCTION

This Plan Document (or “PD”)is to provide You and Your covered Dependents, if any, with information on the benefits, rights and obligations available under the ARCHDIOCESE OF DENVER WELFARE BENEFITS TRUST SELF-FUNDED MEDICAL PLAN (the "**Plan**") of the ARCHDIOCESE OF DENVER WELFARE BENEFITS TRUST (the "**Trust**"). The Plan consists of two (2) Plan Benefits Options that You and Your covered Dependents are eligible to elect at certain times (e.g., upon hiring, during open enrollment). The benefits available under each Plan Benefits Option are enumerated in the sections entitled “Medical Schedule of Benefits” (currently Plan Benefits Options numbering 008, 009 and 010).

As of July 1, 2024, the Effective Date of this Plan Document, the Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this Plan. The Third Party Administrators for the Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and Optum Rx for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under the Plan, as they are solely claims-paying agents of the Plan and the Plan Administrator.

The Trust, through its Participating Entities, has the obligation to fund Plan benefits; however, You help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the applicable Medical Schedule of Benefits.

The Plan is intended to be a “church plan” within the meaning of Code section 414(e) which has not made the election under section 410(d) of the Internal Revenue Code of 1986, as amended (the “Code”). The Plan is also intended to be a “church plan” within the meaning of section 3(33) of the Employee Retirement Income Security Act of 1974 (“ERISA”). The Plan is therefore not subject to the terms of the ERISA. It is intended that the Plan shall be interpreted, wherever possible, to comply with the applicable terms of the Code and all applicable formal regulations and rulings issued under the Code.

Coverage under the Plan takes effect upon confirmation of eligibility, processing/approval of Enrollment documentation, and satisfaction of all other Plan requirements (see the section entitled Enrollment).

The Trustees of the Trust intend that the Plan be maintained indefinitely, but reserve the right to terminate, suspend, discontinue or otherwise amend the Plan at any time and for any reason. If the Plan is terminated or amended, or benefits are eliminated, the rights of You and Your covered Dependents are limited to Covered Expenses Incurred before termination, amendment or elimination. Changes may occur in any or all parts of the Plan, including benefits coverage, Deductibles, maximums, Copays, exclusions, limitations, definitions, eligibility and the like.

Even if You or Your covered Dependents are eligible for coverage, any failure to follow Enrollment requirements may result in delay of coverage or no coverage. Reimbursement from the Plan for benefits otherwise payable can be reduced or denied because of certain Plan provisions, including, but not limited to Coordination of Benefits, Subrogation, exclusions, timeliness of Continuation of Coverage elections, payments, Precertification and Utilization Review Program or other cost management requirements, lack of Medical Necessity, and lack of timely filing of Claims or lack of coverage.

The Plan pays benefits only for expenses Incurred while coverage is in force. No benefits are payable for expenses Incurred before coverage began or after coverage terminated. An expense for a service or supply is deemed Incurred on the date the service or supply is furnished.

No oral interpretations shall in any way alter the terms of this Plan Document. Some terms used in this Plan Document begin with capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Many capitalized terms are listed in the Glossary of Terms, but some terms are defined within the provisions in which they are used.

You and Your covered Dependents will receive a Plan identification card that should be presented to Plan providers upon receipt of covered services. On the back of the card are phone numbers in the event of questions or problems.

COMPLIANCE WITH THE ACA

Per the requirements of the ACA, the Plan (i) consists of Minimum Essential Coverage (per Internal Revenue Code Section 5000A(f)(1)); (ii) provides Minimum Value (per Internal Revenue Code Section 36B(c)(2)(C)(ii)); and, (iii) is Affordable (as those terms are defined in the ACA and related legislation and regulation).

Regarding employer shared responsibility rules under the ACA, the Participating Entities shall comply with regulations issued by the Department of the Treasury providing guidance under Section 4980H of the Internal Revenue Code for purposes of determining employee health benefits coverage. See the "Eligibility" section for additional information.

0PLAN INFORMATION
GENERAL PLAN INFORMATION, ADMINISTRATION AND FUNDING

PLAN NAME
The Archdiocese of Denver Welfare Benefits Trust Self-Funded Medical Plan

PLAN FUNDING and COST OF THE PLAN
The Archdiocese of Denver, the Diocese of Colorado Springs and their respective Participating Entities share the cost with Participants for Participant and Dependent coverage under the Plan as described herein (note: Catholic Charities of Denver is a Participating Entity that is located within the geographical territory of the Archdiocese of Denver). The enrollment application for coverage will include a payroll deduction authorization. The level of Participant contribution is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Participant contributions.
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TYPE OF PLAN
The Plan is a church sponsored self-funded medical plan.

EFFECTIVE DATE OF PLAN DOCUMENT
As amended: July 1, 2024

BENEFIT PLAN YEAR or PLAN YEAR (used for purposes of Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums)
January 1 – December 31

PLAN FISCAL YEAR (used for purposes of open enrollment, premium adjustments, and the ACA standard stability period)
July 1 – June 30

TRUST INFORMATION
The Archdiocese of Denver Welfare Benefits Trust
c/o The Archdiocese of Denver Management Corporation
Attn: President
1300 S. Steele Street
Denver, Colorado 80210

PLAN ADMINISTRATOR
Responsibility for administration of the Plan is with the Plan Administrator: The Archdiocese of Denver Management Corporation.

Send correspondence to:

The Archdiocese of Denver Management Corporation
Attn: President
1300 S. Steele Street
Denver, Colorado 80210

CLAIMS ADMINISTRATOR (current as of July 1, 2023)

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

See the “Prescription Drug Benefits” section of this PD for contact information for Optum Rx.

AUTHORITY AND DUTIES OF THE PLAN ADMINISTRATOR
The Plan Administrator shall have the authority and such powers and rights as may be necessary to discharge its duties, including the authority:

- As permitted by law, to construe and interpret the terms of the Plan, including the authority to remedy possible ambiguities, inconsistencies or omissions;
- To determine appropriate premium rates and collect premium contributions;
- As permitted by law, to decide all questions of Participant eligibility and determine the amount, manner and time of payment of any benefits under the Plan;
- To prescribe rules for the operation of the Plan, including procedures for filing a claim for benefits and review of claim denials;
- To receive and maintain such information from Participants/Dependents as shall be necessary for proper administration of the Plan;
- To engage third party firms to assist in carrying out its responsibilities, and to otherwise delegate any or all of its duties to any properly appointed designees, including the authority to appoint a Claims Administrator to pay claims;
- To settle disputes which may arise in the course of the operation of the Plan.

PLAN ADMINISTRATOR COMPENSATION
The Plan Administrator serves without compensation, provided that the Plan Administrator may be reimbursed by the Plan for expenses incurred in connection with Plan Administrator administration of the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY
The Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS
Funding is derived from the funds of the Trust and contributions made by Participants and Participating Entities. The level of contribution is set by the Plan Administrator. Contributions will be used in funding the cost of the Plan as soon as practicable after such contributions have been withheld from the Participant's pay through payroll deduction, or otherwise received, as applicable. Benefits are paid directly from the Plan through the Claims Administrator.

THE PLAN IS NOT AN EMPLOYMENT CONTRACT
The Plan is not to be construed as a contract for/of employment.

CLERICAL ERROR
Any clerical error in keeping pertinent records or any delay in making any changes, either by the Plan Administrator or any of its agents, will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when any error or delay is discovered. If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return that amount of overpayment. In the case of a Participant, if requested, the amount of overpayment will be deducted from future benefits payable. With respect to clerical errors, the terms of the Plan will control.

MEDICAL SCHEDULE OF BENEFITS

Exclusive Care Plan (Benefit Plan 008)

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

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

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

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

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

	TIER 1 AoD Direct Contracted Providers	**TIER 2 UHC Choice Plus**	**TIER 3 Out-Of-Network**
Annual Deductible Per Calendar Year:			
• Per Person	$0	$6,000	No Benefit
• Per Family	$0	$12,000	No Benefit
– Individual Embedded Deductible	$0	$6,000	No Benefit
Note: Embedded Deductible Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Maximum Family Deductible; However, No One Person Will Pay More Than Their Embedded Individual Deductible Amount.			
Plan Participation Rate, Unless Otherwise Stated Below:			
• Paid By Plan After Satisfaction Of Deductible	100%	50%	No Benefit
Annual Total Out-Of-Pocket Maximum:			
Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.			
• Per Person	$3,000	$9,450	No Benefit
• Per Family	$6,000	$18,900	No Benefit
– Individual Embedded Out-Of-Pocket Maximum	$3,000	$9,450	No Benefit
Note: Embedded Out-Of-Pocket Maximum Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than Their Embedded Individual Out-Of-Pocket Maximum Amount.			

	TIER 1 AoD Direct Contracted Providers	TIER 2 UHC Choice Plus	TIER 3 Out-Of-Network
Acupuncture Treatment:			
• Maximum Visits Per Calendar Year		5 Visits	
• Paid By Plan	100%	50% (Deductible Waived)	50% (Deductible Waived)
Alternative / Complementary Treatment: **Naturopathy:**			
• Maximum Visits Per Calendar Year		5 Visits	
• Paid By Plan	100%	50% (Deductible Waived)	50% (Deductible Waived)
Ambulance Transportation:			
• Paid By Plan	100%	100% (Deductible Waived)	100% (Deductible Waived)
Durable Medical Equipment:			No Benefit
• Paid By Plan	100%	50% (Deductible Waived)	
Emergency Services / Treatment: **Urgent Care:**			No Benefit
• Copay Per Visit	$50	$50	
• Paid By Plan	100%	100% (Deductible Waived)	
Emergency Room Only:			
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24)	$300	$300	$300
• Paid By Plan	100%	100% (Deductible Waived)	100% (Deductible Waived)
Emergency Physicians Only:			
• Paid By Plan	100%	100% (Deductible Waived)	100% (Deductible Waived)
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:			No Benefit
• Maximum Days Per Calendar Year		60 Days	
• Paid By Plan	100%	50% (Deductible Waived)	

	TIER 1 AoD Direct Contracted Providers	TIER 2 UHC Choice Plus	TIER 3 Out-Of-Network
Home Health Care Benefits:			No Benefit
• Maximum Visits Per Calendar Year	100 Visits		
• Paid By Plan	100%	50% (Deductible Waived)	
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.			
Hospice Care Benefits:			No Benefit
Hospice Services:			
• Paid By Plan	100%	50% (Deductible Waived)	
Bereavement Counseling:			
• Paid By Plan	100%	50% (Deductible Waived)	
Hospital Services:			No Benefit
Pre-Admission Testing:			
• Paid By Plan After Deductible	100%	50%	
Inpatient Services Only; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:			
• Copay Per Admission	$500	Not Applicable	
• Paid By Plan After Deductible	100%	50%	
Inpatient Physician Charges Only:			
• Paid By Plan After Deductible	100%	50%	
Outpatient Services / Outpatient Physician Charges:			
• Paid By Plan After Deductible	100%	50%	
Outpatient Advanced Imaging Charges:			
• Copay Per Occurrence	$150	Not Applicable	
• Paid By Plan After Deductible	100%	50%	
Outpatient Lab And X-Ray Charges:			
• Paid By Plan After Deductible	100%	50%	
Outpatient Surgery / Surgeon Charges:			
• Copay Per Occurrence	$250	Not Applicable	
• Paid By Plan After Deductible	100%	50%	

	TIER 1 AoD Direct Contracted Providers	TIER 2 UHC Choice Plus	TIER 3 Out-Of-Network
Physician Clinic Visits In An Outpatient Hospital Setting - Facility Claim: • Paid By Plan After Deductible	100%	50%	
Physician Clinic Visits In An Outpatient Hospital Setting - Physician Claim: • Copay Per Visit - Primary Care Physician • Copay Per Visit - Specialist • Paid By Plan After Deductible	$0 $40 100%	Not Applicable Not Applicable 50%	
Manipulations: • Maximum Visits Per Calendar Year • Paid By Plan **Visit Maximums Are Applied Based On Provider Designation And Procedure Code.** **If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation.**	100%	20 Visits 50% (Deductible Waived)	50% (Deductible Waived)
Maternity: **Routine Prenatal Services:** • Paid By Plan **Non-Routine Prenatal Services, Delivery, And Postnatal Care:** • Paid By Plan After Deductible	100% 100%	100% (Deductible Waived) 50%	No Benefit
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits: **Inpatient Services Only:** • Copay Per Admission • Paid By Plan After Deductible **Inpatient Physician Charges Only:** • Paid By Plan After Deductible **Residential Services Only:** • Copay Per Admission • Paid By Plan After Deductible	$500 100% 100% $500 100%	Not Applicable 50% 50% Not Applicable 50%	No Benefit No Benefit No Benefit

	TIER 1 AoD Direct Contracted Providers	TIER 2 UHC Choice Plus	TIER 3 Out-Of-Network
Residential Physician Charges Only: • Paid By Plan After Deductible	100%	50%	No Benefit
Outpatient Or Partial Hospitalization Services And Physician Charges: • Paid By Plan	100%	100% (Deductible Waived)	100% (Deductible Waived)
Office Visit: • Paid By Plan	100%	100% (Deductible Waived)	100% (Deductible Waived)
Natural Family Planning (NFP) And Associated Supplies: • Maximum Benefit Per Calendar Year • Paid By Plan	NFP Classes And NFP Associated Supplies Up To $500 100%	100% (Deductible Waived)	No Benefit
Nursery And Newborn Expenses: • Paid By Plan After Deductible ***Note: Deductible And / Or Co-pay Will Be Waived For Preventive / Routine Well Newborn Charges During The Initial Stay (Days 0-5).***	100%	50%	No Benefit
Orthotic Appliances: • Paid By Plan After Deductible	100%	50%	No Benefit
Shoe Inserts-Custom Molded: • Maximum Benefit Every 2 Calendar Years • Paid By Plan After Deductible	1 Pair 50%	50%	

	TIER 1 AoD Direct Contracted Providers	TIER 2 UHC Choice Plus	TIER 3 Out-Of-Network
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility** **Office Visit:** • Copay Per Visit - Specialist • Paid By Plan After Deductible **The Copays Will Not Apply To:** ➢ **Independent Lab** ➢ **Services Billed By Radiologist Or Pathologist Including Independent Radiology Facility (Freestanding Radiology Facility)**	 $40 100%	 Not Applicable 50%	No Benefit
Physician Office Services: • Paid By Plan After Deductible **Diagnostic X-Ray And Laboratory Tests:** • Paid By Plan After Deductible **Office Advanced Imaging:** • Copay Per Visit • Paid By Plan After Deductible	 100% 100% $150 100%	 50% 50% Not Applicable 50%	No Benefit
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: **Preventive / Routine Physical Exams At Appropriate Ages:** • Paid By Plan	 100%	 100% (Deductible Waived)	No Benefit

	TIER 1 AoD Direct Contracted Providers	TIER 2 UHC Choice Plus	TIER 3 Out-Of-Network
Immunizations:			
• Paid By Plan	100%	100% (Deductible Waived)	
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:			
• Paid By Plan	100%	100% (Deductible Waived)	
Preventive / Routine Mammograms And Breast Exams:			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Plan	100%	100% (Deductible Waived)	
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum			
• Paid By Plan	100%	100% (Deductible Waived)	
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:			
• Paid By Plan After Deductible	100%	50%	
Preventive / Routine Pelvic Exams And Pap Tests:			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Plan	100%	100% (Deductible Waived)	
Preventive / Routine PSA Test And Prostate Exams:			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Plan	100%	100% (Deductible Waived)	
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:			
• Paid By Plan	100%	100% (Deductible Waived)	

	TIER 1 AoD Direct Contracted Providers	TIER 2 UHC Choice Plus	TIER 3 Out-Of-Network
Preventive / Routine Hearing Exams: • Paid By Plan	100%	100% (Deductible Waived)	
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan ***These Services May Also Apply To Men.**	100%	100% (Deductible Waived)	
Prosthetics: • Paid By Plan After Deductible	100%	50%	No Benefit
Teladoc Services: **General Medicine:** • Paid By Plan **Dermatology:** • Paid By Plan **Behavioral Health:** • Paid By Plan	100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived)		
Telehealth: • Paid By Plan	100%	100% (Deductible Waived)	No Benefit
Temporomandibular Joint Disorder Benefits: • Maximum Benefit Per Lifetime • Paid By Plan	1 Course Of Treatment 100%	100% (Deductible Waived)	No Benefit

	TIER 1 AoD Direct Contracted Providers	TIER 2 UHC Choice Plus	TIER 3 Out-Of-Network
Therapy Services: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	60 Visits 100%	50%	No Benefit
Massage Therapy: • Maximum Visits Per Calendar Year • Paid By Plan ***Note: Medical Necessity Will Be Reviewed After 25 Visits.***	10 Visits 100%	50% (Deductible Waived)	50% (Deductible Waived)
Vision Care Benefits: • Paid By Plan After Deductible	100%	50%	No Benefit
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Calendar Year • Paid By Plan	1 Wig (Cranial Prosthesis), Toupee, Or Hairpiece 100%	100% (Deductible Waived)	No Benefit
All Other Covered Expenses: • Paid By Plan After Deductible	100%	50%	No Benefit

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 009, 010

This Plan has the required elements for You to be able to contribute to a tax-advantaged Health Savings Account (HSA).

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

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

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

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

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

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Deductible.***		
• Single Coverage	$3,200	$8,000
• Family Coverage	$6,400	$16,000
– Individual Embedded Deductible	$3,200	$8,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	50%
Annual Total Out-Of-Pocket Maximum: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.***		
• Single Coverage	$6,000	$16,000
• Family Coverage	$12,000	$32,000
– Individual Embedded Out-Of-Pocket Maximum	$6,000	$16,000
Acupuncture Treatment:		
• Maximum Visits Per Calendar Year	5 Visits	
• Paid By Plan After Deductible	80%	50%
Ambulance Transportation:		
• Paid By Plan After In-Network Deductible	80%	80%
Durable Medical Equipment:		
• Paid By Plan After Deductible	80%	50%

	IN-NETWORK	OUT-OF-NETWORK
Emergency Services / Treatment: • Paid By Plan After In-Network Deductible	80%	80%
Urgent Care: • Paid By Plan After Deductible	80%	50%
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: • Maximum Days Per Calendar Year • Paid By Plan After Deductible	60 Days 80%	50%
Home Health Care Benefits: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.***	100 Visits 80%	50%
Hospice Care Benefits: **Hospice Services:** • Paid By Plan After Deductible **Bereavement Counseling:** • Paid By Plan After Deductible	80% 80%	50% 50%
Hospital Services: • Paid By Plan After Deductible **Pre-Admission Testing:** • Paid By Plan After Deductible **Outpatient Advanced Imaging Charges:** • Paid By Plan After Deductible **Outpatient Lab And X-Ray Charges:** • Paid By Plan After Deductible **Outpatient Surgery / Surgeon Charges:** • Paid By Plan After Deductible **Physician Clinic Visits In An Outpatient Hospital Setting:** • Paid By Plan After Deductible	80% 80% 80% 80% 80% 80%	50% 50% 50% 50% 50% 50%
Manipulations: • Maximum Visits Per Calendar Year • Paid By Plan After Deductible **Visit Maximums Are Applied Based On Provider Designation And Procedure Code.** **If A Provider Bills For A Manipulation And A Therapy On The Same Claim, Only One Visit Will Be Applied To The Manipulation Maximum Based On The Provider's Designation.**	20 Visits 80%	50%

	IN-NETWORK	OUT-OF-NETWORK
Maternity:		
Routine Prenatal Services:		
• Paid By Plan	100% (Deductible Waived)	50%
Non-Routine Prenatal Services, Delivery, And Postnatal Care:		
• Paid By Plan	80%	50%
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits:		
• Paid By Plan After Deductible	80%	50%
Natural Family Planning (NFP) And Associated Supplies:		
• Maximum Benefit Per Calendar Year	NFP Classes And NFP Associated Supplies Up To $500	
• Paid By Plan After Deductible	100%	100%
Orthotic Appliances:		
• Paid By Plan After Deductible	80%	50%
Shoe Inserts-Custom Molded:		
• Maximum Benefit Every 2 Calendar Years	1 Pair	
• Paid By Plan After Deductible	80%	50%
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility**		
• Paid By Plan After Deductible	80%	50%
Physician Office Services:		
• Paid By Plan After Deductible	80%	50%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: **Preventive / Routine Physical Exams At Appropriate Ages:**		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Immunizations:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Mammograms And Breast Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:		
• Paid By Plan After Deductible	80%	50%
Preventive / Routine Pelvic Exams And Pap Tests:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine PSA Test And Prostate Exams:		
• Maximum Exams Per Calendar Year	1 Exam	
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
• Paid By Plan After Deductible	80%	50%
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Hearing Exams:		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***		
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
***These Services May Also Apply To Men.**		

	IN-NETWORK	OUT-OF-NETWORK
Teladoc Services: **General Medicine:** • Paid By Plan After Deductible	80%	
Dermatology: • Paid By Plan After Deductible	80%	
Behavioral Health: • Paid By Plan After Deductible	80%	
Temporomandibular Joint Disorder Benefits: • Maximum Benefit Per Lifetime	1 Course Of Treatment	
• Paid By Plan After Deductible	80%	50%
Therapy Services: • Maximum Visits Per Calendar Year	60 Visits	
• Paid By Plan After Deductible	80%	50%
Massage Therapy: • Maximum Visits Per Calendar Year	10 Visits	
• Paid By Plan After Deductible	80%	50%
Vision Care Benefits: • Paid By Plan After Deductible	80%	50%
Wigs (Cranial Prostheses), Toupees, Or Hairpieces Related To Cancer Treatment And Alopecia Areata: • Maximum Benefit Per Calendar Year	1 Wig (Cranial Prosthesis), Toupee, Or Hairpiece	
• Paid By Plan After In-Network Deductible	80%	80%
All Other Covered Expenses: • Paid By Plan After Deductible	80%	50%

TRANSPLANT SCHEDULE OF BENEFITS **The program for Transplant Services at Designated Transplant Facilities is:** **Optum** **Benefit Plan(s) 008**	
Transplant Services: Designated Transplant Facility **Transplant Services:** • Paid By Plan **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	 100% $10,000 100%

TRANSPLANT SCHEDULE OF BENEFITS **The program for Transplant Services at Designated Transplant Facilities is:** **Optum** **Benefit Plan(s) 009, 010**	
Transplant Services: Designated Transplant Facility **Transplant Services:** • Paid By Plan After Deductible **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan After Deductible Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	 80% $10,000 100%

PRESCRIPTION SCHEDULE OF BENEFITS OPTUM RX Benefit Plan(s) 008	
Annual Pharmacy Out-Of-Pocket Maximum Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Out-Of-Pocket Maximum.*** • Per Person • Per Family – Individual Embedded Out-Of-Pocket Maximum ***Note: Embedded Out-Of-Pocket Maximum Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than Their Embedded Individual Out-Of-Pocket Maximum Amount.***	 $3,000 $6,000 $3,000
By Participating Retail Pharmacy • Covered Person's Copay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Preferred Brand-Name And Some Generic) Tier 3 (Nonpreferred Brand-Name And Nonpreferred Generic)	 For Up To A 30-Day Supply: $10 $30 $50
By Optum Rx Home Delivery • Covered Person's Copay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Preferred Brand-Name And Some Generic) Tier 3 (Nonpreferred Brand-Name And Nonpreferred Generic)	 For Up To A 90-Day Supply: $20 $60 $100
Specialty Drugs • Covered Person's Copay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Preferred Brand-Name And Some Generic) Tier 3 (Nonpreferred Brand-Name And Nonpreferred Generic) ***Note: Certain Specialty Prescription Drugs May Be Subject To A Separate Cost Share. For Further Information, Call 877-559-2955.***	 For Up To A 30-Day Supply: 20% With A Maximum Of $200 20% With A Maximum Of $200 20% With A Maximum Of $200
By Non-Participating Pharmacy	No Benefit

PRESCRIPTION SCHEDULE OF BENEFITS OPTUM RX Benefit Plan(s) 009, 010	
Annual Pharmacy Deductible Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Deductible.*** • Per Person • Per Family – Individual Embedded Deductible	 $3,200 $6,400 $3,200
Annual Pharmacy Out-Of-Pocket Maximum Per Calendar Year: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Medical Out-Of-Pocket Maximum.*** • Per Person • Per Family – Individual Embedded Out-Of-Pocket Maximum	 $6,000 $12,000 $6,000
By Participating Retail Pharmacy • Covered Person's Copay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Preferred Brand-Name And Some Generic) Tier 3 (Nonpreferred Brand-Name And Nonpreferred Generic)	 For Up To A 30-Day Supply: 20% 20% 20%
By Optum Rx Home Delivery • Covered Person's Copay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Preferred Brand-Name And Some Generic) Tier 3 (Nonpreferred Brand-Name And Nonpreferred Generic)	 For Up To A 90-Day Supply: 20% 20% 20%
Specialty Drugs • Covered Person's Copay Amount Tier 1 (Generic And Some Brand-Name) Tier 2 (Preferred Brand-Name And Some Generic) Tier 3 (Nonpreferred Brand-Name And Nonpreferred Generic) ***Note: Certain Specialty Prescription Drugs May Be Subject To A Separate Cost Share. For Further Information, Call 877-559-2955.***	 For Up To A 30-Day Supply: 20% 20% 20%
By Non-Participating Pharmacy	No Benefit

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 008

COPAYS

A Copay is the amount that the Covered Person pays each time certain services are received. The Copay is typically a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not apply toward satisfaction of Deductibles. Copays apply toward satisfaction of out-of-pocket maximums. The Copay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

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

Deductible amounts are shown on the Schedule of Benefits.

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

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

Any amount that the Covered Person pays for Covered Expenses during the last three months of the prior Plan Year, and that are used to satisfy the individual and family Deductible for that year, will also be applied toward current Plan Year individual and family Deductible requirement.

PLAN PARTICIPATION

Plan Participation is the percentage of Covered Expenses that the Covered Person is responsible for paying after the Deductible is met. The Covered Person pays this percentage until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits.

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

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of the Covered Expenses through the end of the Plan Year.

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

- Medical Copays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.

- Pharmacy Copays and Plan Participation amounts for Prescription benefits.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays.

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

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 009, 010

COPAYS

A Copay is the amount that the Covered Person pays each time certain services are received. The Copay is typically a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not apply toward satisfaction of Deductibles. Once the Deductible is met, the Copay will apply. Copays apply toward satisfaction of out-of-pocket maximums. The Copay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

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

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

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

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

Any amount that the Covered Person pays for Covered Expenses during the last three months of the prior Plan Year, and that are used to satisfy the individual and family Deductible for that year, will also be applied toward current Plan Year individual and family Deductible requirement.

PLAN PARTICIPATION

Plan Participation is the percentage of Covered Expenses that the Covered Person is responsible for paying after the Deductible is met. The Covered Person pays this percentage until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits.

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

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of the Covered Expenses through the end of the Plan Year.

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

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

- Any charges above the limits specified elsewhere in this document.
- Pharmacy Copays and Plan Participation amounts for Prescription benefits.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays.

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

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

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

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

ELIGIBILITY

The Plan's eligibility procedures include administrative safeguards and processes designed to ensure and verify that eligibility determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other similarly situated individuals who are eligible to participate in the Plan.

PARTICIPANT ELIGIBILITY REQUIREMENTS

1. Classes of Individuals Eligible to Participate as Participants under the Plan. A person who satisfies the following eligibility requirements shall be referred to herein as a "Person(s) Eligible to Participate" even though such person is not Enrolled in the Plan:

a. Full-time non-teaching employee employed by a Participating Entity who is regularly scheduled to work 30 or more hours per week;

b. Full-time teacher or school employee employed by a Participating Entity who is regularly scheduled to work 30 or more hours per week for the contracted academic year;

c. A seminary student of the Archdiocese of Denver or the Diocese of Colorado Springs;

d. An active, retired or disabled priest incardinated into the Archdiocese of Denver or the Diocese of Colorado Springs;

e. A religious sister, brother, extern priest or order priest employed by a Participating Entity who is regularly scheduled to work 30 or more hours per week;

f. An employee of a Participating Entity described in paragraphs a through e. above who is not regularly scheduled to work 30 or more hours per week but satisfies the requirements described in paragraph (2) below.

2. **Individuals Eligible to Participate Under ACA Measurement Period Rules.** An employee of a Participating Entity who becomes eligible to participate in the Plan pursuant to the rules described below in this paragraph (2) will be considered a Person Eligible to Participate for the period that such employee is eligible to participate in the Plan**.**

a. New Employees: If an employee of a Participating Entity is determined to have been employed on average at least 130 hours per month during the employee's "initial measurement period", such employee will become eligible to participate in the medical benefits under the Plan for the "initial stability period" that follows such initial measurement period and the "initial administrative period". Such employee's eligibility to participate for periods after the initial stability period will be subject to the "standard measurement period" rules for ongoing employees, as described below. For purposes of this paragraph.

- An "initial measurement period" is the 12-month period beginning on the employee's first day of employment with the Participating Entity.

- An "initial administrative period" is the period from the end of the initial measurement period through the end of the first calendar month beginning on or after the end of the initial measurement period.

- An “initial stability period” is the 12-month period beginning on the first day of the first calendar month beginning after the end of the initial administrative period.

b. Ongoing Employees: If an employee is determined to have been employed on average at least 130 hours per month during a “standard measurement period”, the employee will become eligible to participate in the Plan for the “standard stability period” that follows such standard measurement period. An employee who is determined not to have been employed an average of at least 130 hours per month during a standard measurement period will not be eligible to participate in the Plan for the standard stability period that follows such standard measurement period (though an employee who was eligible to participate during an initial stability period will remain eligible for that entire initial stability period). For purposes of this paragraph:

- A “standard measurement period” will begin on May 1 of a calendar year and end on April 30 of the following calendar year. For example, a standard measurement period will be May1, 2020 – April 30, 2021. There will be an “administrative period from May1 to June 30 during which the Participating Entity will process enrollment activity.

- A “standard stability period” will begin on July 1 of a calendar year and end on June 30 of the following calendar year. For example, a standard stability period will be July 1, 2020 to June 30, 2021.

c. Hours of Service: The determination of hours of service will be made in accordance with guidance issued regarding the determination of “full-time employee” for purposes of Section 4980H of the Internal Revenue Code.

d. Change in Status:

- If an employee who is not a full-time employee (and thus is not eligible to participate in the medical benefits under the Plan) changes status to a full-time employee during an initial measurement period, such employee will become eligible to participate in the Plan. If an employee properly enrolls in coverage, then coverage will be effective as of the first day of the fourth full calendar month following the date of the change in status to a full-time employee (or, if earlier, and the employee averages at least 130 or more hours per month during the initial measurement period, the first day of the initial stability period). To begin coverage, the Plan Administrator must receive a properly completed enrollment request prior to the effective date of coverage.
- t least 130 or more hours per month during the initial measurement period, the first day of the initial stability period). To begin coverage, the Plan Administrator must receive a properly completed enrollment request prior to the effective date of coverage.
- least 130 or more hours per month during the initial measurement period, the first day of the initial stability period). To begin coverage, the Plan Administrator must receive a properly completed enrollment request prior to the effective date of coverage.

- If a full-time employee ceases to be a full-time employee during a Plan Fiscal Year, the following rules will apply:

  - If such change occurs before the employee has completed at least one standard measurement period, such employee will cease to be eligible to participate in the medical benefits under the Plan as of the last day of the month in which the status change occurred.

- If such change occurs after the employee has completed at least one standard measurement period and such employee was employed an average of at least 130 hours per month during the standard measurement period associated with the current standard stability period, such employee will remain eligible for the medical benefits under the Plan for the remainder of the current standard stability period, except to the extent provided in the next sentence. If the following three conditions are satisfied, then an employee ceases to be a full-time employee and ceases to be eligible for medical benefits on the last day of the third full calendar month after the change in employment status:
- ployee ceases to be a full-time employee and ceases to be eligible for medical benefits on the last day of the third full calendar month after the change in employment status:
- loyee ceases to be a full-time employee and ceases to be eligible for medical benefits on the last day of the third full calendar month after the change in employment status:

    - The employer has offered the employee minimum value coverage continuously during the period beginning on the first day of the calendar month following the employee's initial three full calendar months of employment through the calendar month in which the change in employment status described in this section occurs;
    - The employee has a change in employment status to a position or status in which the employee would not have reasonably been expected to be a full-time employee if the employee had begun employment in that position or status; and
    - t in that position or status; and
    - The employee actually is credited with less than 130 hours of service for each of the three full calendar months following such change in employment status.

- The employee's eligibility for future stability periods will be determined in accordance with the rules for ongoing employees as described above.

3. <u>Rehires</u>

a. Participating Entities consist of both School and Non-School Ministries. Under the ACA, different Participant reinstatement of coverage rules apply to each type of ministry, per the following:

- **Non-School Ministries** – Applicable to Participants who are NOT working either (i) for a stand-alone school, or (ii) within a parish school ministry (meaning, the Participant is working either within a parish's general ministry or for a non-school entity): If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the ACA) within 13 weeks from the date Your coverage ended, you will be treated as a continuing employee. If you are treated as a continuing employee, you will retain, upon resumption of services, the status that you had with respect to the application of any stability period. For example, if you return during a stability period in which you were treated as a full-time employee, you will be treated as a full-time employee upon return and through the end of that stability period. In such a case, your coverage election at the time of termination will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the ACA) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13- week period, You will be treated as a new hire and will be required to meet all the requirements of a new employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

- **School Ministries** – Applicable to Participants who are working either (i) for a stand-alone school, or (ii) within a parish school ministry: If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the ACA) within 26 weeks from the date Your coverage ended, you will be treated as a continuing employee. If you are treated as a continuing employee, you will retain, upon resumption of services, the status that you had with respect to the application of any stability period. For example, if you return during a stability period in which you were treated as a full-time employee, you will be treated as a full-time employee upon return and through the end of that stability period. In such a case, your coverage election at the time of termination will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the ACA) within 26 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 26-week period, You will be treated as a new hire and will be required to meet all the requirements of a new employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Human Resources or Personnel office.

4. **Leave of Absence**.

a. A Participant may retain eligibility for coverage under this Plan if the Participant is temporarily absent on an approved leave of absence, which is combined with the Participating Entity's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the Participating Entity's leave policy, provided that contributions continue to be paid on a timely basis.

b. Continuation of Coverage is not applicable until short-term disability is exhausted.

The Plan Administrator shall have the authority to interpret and apply the rules described above in accordance with applicable law, including the statutory, regulatory and other guidance issued regarding the determination of "full-time employees" for purposes of Section 4980H of the Internal Revenue Code.

Persons Eligible to Participate during a measurement period as required by the ACA regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The Participating Entity's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether the employer agrees to such reclassification, will change a person's eligibility for benefits.

DEPENDENT ELIGIBILITY REQUIREMENTS

1. Classes of Individuals Eligible to Participate as Dependents under the Plan. Except as provided in subparagraph (2), below, the following persons qualify as "Eligible Dependent(s)" who, if Enrolled in the Plan, may be eligible for benefits under the Plan:

a. A Participant's Spouse (the term "Spouse" means the person recognized as a Participant's husband or wife by the universal and particular law of the Catholic Church who is in a marriage between one man and one woman, and includes a Spouse in a civil law common law marriage (a common law marriage must be attested to by submission to the Plan Administrator of a fully executed affidavit utilizing a form approved by the Plan Administrator).

b. A Participant's child(ren) from birth to the limiting age of 26 years, subject to the following:

i. The term “child(ren)” means natural child(ren), adopted child(ren), Foster Child(ren), stepchild(ren) or child(ren) lawfully placed with a Participant in anticipation of legal adoption. A child shall remain an Eligible Dependent until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency or residency status with the Participant or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child’s birthday month. However, for Plan years beginning before January 1, 2014, a Participant’s child is not an Eligible Dependent if the child is eligible to enroll in an employer sponsored health plan other than the group health plan of a parent of the child.

ii. If a Participant is the Legal Guardian of an unmarried child(ren), such child(ren) may be enrolled in the Plan as Dependents.

iii. The phrase “child(ren) placed with a Participant in anticipation of adoption” refers to a child whom the Participant intends to adopt, regardless of whether the adoption has become final. The term “placed” means the assumption and retention by Participant of a legal obligation for total or partial support of the child in anticipation of adoption of the child.

iv. Any child of a Participant who is an alternate recipient under a qualified medical child support order (QMCSO) shall be considered as having a right to be classified as a Dependent under the Plan. A Participant may obtain from the Plan Administrator, without charge, a copy of the procedures governing QMCSO determinations.

c. A Dependent child who reaches the limiting age (26) and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the Participant for support and maintenance and unmarried, subject to the requirements set forth below under “Extended Coverage for Dependent Children.”

2. <u>Extended Coverage for Dependent Children.</u>

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

- The Dependent Child was covered by this Plan on the day before the Child’s 26th birthday; or
- The Dependent Child is a Dependent of a Participant newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the applicable Section 125 Plan.

To be an eligible Totally Disabled Dependent Child, the following conditions must all be met:

- A Totally Disabled Dependent Child age 26 or over must be dependent upon the Participant for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a QMCSO because of the Participant’s divorce or separation decree.
- A Totally Disabled Dependent Child age 26 or over must be unmarried. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time; thereafter, the Plan may ask for proof not more than once per year.
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable). The Plan Administrator reserves the right to have such Dependent child examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.
- The Dependent must not be able to hold a self-sustaining job due to the disability.
- The Participant must still be covered under this Plan.

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

3. **<u>Persons Excluded as Eligible Dependents</u>. The following individuals will NOT be treated as Eligible Dependents under the Plan:**

   a) other individuals living in the Participant's home who are not eligible as defined herein;

   b) the legally separated or divorced former Spouse of the Participant, unless the separation agreement, decree of separation, or divorce decree mandates that such person shall be covered under the terms of the Plan, in which event such legally separated or divorced former Spouse shall, for purposes of Plan administration (including, without limitation, the maximum out-of-pocket limit for a family and any family limit on Deductibles), be considered a member of the Participant's family;

   c) any spouse of a Participant who is on active duty in any military service of any country;

   d) any person who is already deemed a Participant under the Plan

   e) A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship; unless he or she qualifies as a Child of the Participant;

   f) A grandchild; unless he or she qualifies as a Child of the Participant;

   g) A Domestic Partner;

   h) A Dependent Child if the Child is covered as a Dependent of another Participant;

   i) Any other relative or individual unless explicitly covered by this Plan.

4. **<u>Timing of Dependent Eligibility; Other Eligibility Requirements and Considerations</u>.**

   a) A Dependent is eligible for Dependent coverage (i) on the first day that the Participant is eligible for Participant coverage, and (ii) upon that individual meeting the Eligible Dependent requirements conditions specified herein.

   b) At any time, the Plan may require proof that a Spouse or child qualifies or continues to qualify as a Participant's Eligible Dependent as defined herein.

   c) If an individual covered under the Plan changes status from Participant to Dependent or from Dependent to Participant, and that individual is covered continuously under the Plan before, during and after such change in status, credit will be given for Deductibles and all amounts applied to maximums.

If both a child's mother and father are Participants, that child may be covered as a Dependent of either the mother or the father, but not of both. If a Child is Eligible for coverage as both a Participant and a Dependent, the Child may be covered as a Participant or a Dependent, but not both.

For purposes of this Plan, eligibility requirements are used to determine a person's initial and continuing Eligibility for coverage under this Plan.

5. Right to Check a Dependent's Eligibility Status

The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Benefits Office regarding status changes.

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

Participants have the right to choose which Eligible Dependents are covered under the Plan.

ENROLLMENT

ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by the Plan Administrator. The Plan's enrollment procedures include administrative safeguards and processes designed to ensure and verify enrollment occurs in accordance with the Plan. The coverage choices that will be offered to You will be the same choices offered to other similarly situated individuals who are eligible to participate in the Plan.

DEFINITIONS
(not alphabetical)

"Day(s)" or "**day(s)"** means calendar days, not business days.

"Enroll(ment)" refers to the process whereby (i) a Participant completes, signs and submits the Plan's enrollment application with all required supporting documentation to the Plan Administrator, and (ii) arrangements for payment of the corresponding premium contribution have been made either through automatic payroll deduction or otherwise, as approved by the Plan Administrator. The enrollment application may be submitted either electronically per the electronic enrollment protocols (provided by the Plan Administrator), or submitted in paper form directly to the Plan Administrator.

"Enrollment Date" is the date that a Participant's Enrollment is completed and has been filed with the Plan Administrator, provided that such materials are thereafter approved by the Plan Administrator. This may or may not be the same date as the Effective Date of Coverage. See below for timing examples specific to each Enrollment Option.

"Effective Date of Coverage" is the date on which Plan eligibility conditions have been met, the Participant has enrolled, and coverage under the Plan commences as approved herein. In the case of Dependents, a Participant's Dependent(s) cannot have an Effective Date of Coverage that is prior to the Participant's Effective Date of Coverage. See below for timing examples specific to each Enrollment Option.

"Start Date" refers to (i) the date that employment commences with a Participating Entity if the Person Eligible to Participate is an employee (i.e., the individual is not a seminary student or an incardinated priest as further described in the section herein entitled "ELIGIBILITY"); (ii) the day a seminarian is required to report to seminary classes for the first time (Seminary continues for a period of years; once effective, coverage under the Plan for a seminarian continues for so long as he is enrolled in seminary or until such other termination event occurs) if the Person Eligible to Participate is a seminary student; or (iii) the day of incardination if the Person Eligible to Participate is an incardinated priest. In the case of employees of Participating Entities, the Start Date may also be termed the "**Date of Hire**".

"Waiting Period" refers to any period of delay in coverage under the Plan resulting from the difference in timing between the Start Date and the Effective Date of Coverage.

"Enrollment Options" refers to the alternatives under which a Participant and his/her Dependents may qualify to Enroll in the Plan. These Enrollment Options are summarized as follows and more particularly described below:

"General Enrollment" is Enrollment that is directly tied to the Start Date of a Person Eligible to Participate. See below for specific provisions under which General Enrollment may proceed.

"Open Enrollment" is Enrollment wherein either a Person Eligible to Participate or a Participant, as applicable, shall be permitted to enroll him/herself and/or his/her Eligible Dependents, in the Plan. Open Enrollment is not tied to Start Date. To be eligible for Open Enrollment, neither a Person Eligible to Participate nor a Participant is required to experience a Special Enrollment Event.

"Special Enrollment" is a right to enroll in the Plan, or change coverage under the Plan, that is not tied to the Start Date of a Person Eligible to Participate, but rather relates to a "**Special Enrollment Event**". A Special Enrollment Event includes, but is not limited to, a birth, a marriage, (marriage shall be between a man and a woman consistent with the universal and particular law of the Catholic Church, and shall include a civil law common law marriage that must be attested to by submission to the Plan Administrator of a fully executed affidavit utilizing a form approved by the Plan Administrator) an adoption, a loss of coverage under a Spouse's plan, etc. See the next Section for the specific provisions under which Special Enrollment may proceed.

"Enrollment Per Medicaid & State Child Health Insurance Programs" is Enrollment that is permitted as a result of certain changes to the coverage under a Medicaid plan under Title XIX of the Social Security Act or per a state Child Health Insurance Plan (CHIP) under Title XXI of the Social Security Act.

ENROLLMENT APPLICATION; PREMIUM PAYMENT REQUIREMENTS.

To obtain benefits under the Plan, a Person Eligible to Participate must enroll in the Plan. Regardless of the Enrollment Option chosen, a Person Eligible to Participate must Enroll for coverage for him/herself and any Eligible Dependents by submitting a completed enrollment application (paper or electronic). The enrollment application is available through the Plan Administrator.

REGARDLESS OF THE START DATE, COVERAGE SHALL BE EFFECTIVE PRIOR TO ENROLLMENT ONLY UNDER LIMITED CIRCUMSTANCES AS SET FORTH HEREIN, AND THEN ONLY IF THE ENROLLMENT APPLICATION IS SUBMITTED WITHIN THE REQUISITE TIME PERIOD APPLICABLE UNDER THE ENROLLMENT OPTION CHOSEN AND APPROVED BY THE PLAN ADMINISTRATOR.

Where applicable, the enrollment application shall also serve as a payroll deduction authorization.

Note: Eligible individuals who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage due to coverage under another group health plan or health insurance policy must state in writing that enrollment is declined due to other coverage. If an eligible individual does not provide the required statement, the Plan is not required to provide special enrollment to the eligible individual or any eligible dependents upon a loss of certain types of coverage. See the Special Enrollment Provision section of this Plan.

ENROLLMENT OPTIONS.

More particularly described below, the Plan has the following Enrollment Options: (1) General Enrollment, (2) Open Enrollment, (3) Special Enrollment, and (4) Enrollment Per Medicaid & State Child Health Insurance Programs.

IF A PERSON ELIGIBLE TO PARTICIPATE DOES NOT ENROLL WITHIN THIRTY-ONE (31) DAYS OF HIS/HER START DATE, OR DURING AN OPEN ENROLLMENT PERIOD (WHICH OPEN ENROLLMENT MAY OR MAY NOT BE SCHEDULED, AND IF SCHEDULED, SHALL BE SCHEDULED NO MORE THAN ANNUALLY AND AT THE DISCRETION OF THE PLAN ADMINISTRATOR), IT IS POSSIBLE THAT NEITHER THE PERSON ELIGIBLE TO PARTICIPATE NOR HIS/HER ELIGIBLE DEPENDENT(S) MAY SUBSEQUENTLY BE ELIGIBLE TO ENROLL IN THE PLAN UNDER ANY OTHER ENROLLMENT OPTIONS.

Regardless of the Enrollment Option available, a Person Eligible to Participate must Enroll him/herself in the Plan before his/her Eligible Dependents may be permitted to Enroll.

A Participant and his/her Eligible Dependents must Enroll under the same Plan Benefits Option.

1. **General Enrollment.** General Enrollment is available to all Persons Eligible to Participate, provided that such individual Enrolls him/herself and any Eligible Dependents under any one of the Plan Options within thirty-one (31) days of the Start Date (day one of such thirty-one day period being the Start Date).

    a. **Effective Date of Coverage**. Upon Enrollment, the Effective Date of Coverage under General Enrollment is the first day of the month that is coincident with, or next following, the Start Date of the Person Eligible to Participate EXCEPT that if the Start Date is the first working day of the month (meaning, a Monday, regardless of whether a recognized holiday), the Effective Date of Coverage in such instance shall be retroactive to either that previous Saturday or Sunday, whichever is the first day of the month. See Timing Examples, below:

    b. **Timing Examples**.

        i. New employee A / New Seminarian A / Newly Incardinated Priest A

        IF: Start Date of Nov 1; Enrollment completed Nov 1

        THEN: Effective Date of Coverage and Enrollment Date are both Nov 1; no Waiting Period

        ii. New employee B / New Seminarian B / Newly Incardinated Priest B

        IF: Start Date of Nov 2 (which date is not the first working day of month); Enrollment completed Nov 20

        THEN: Enrollment Date is Nov 20; Effective Date of Coverage is Dec 1; Waiting Period is from Nov 2 through Nov 30

        iii. New employee C / New Seminarian C / Newly Incardinated Priest C

        IF: Start Date of Nov 1; the Person Eligible to Participate intends to Enroll within the mandatory thirty-one (31) days of his/her Start Date, but does not do so and an intervening Medical Emergency occurs prior to the expiration of the thirty-one days (expiring on Dec 1).

        THEN: The Person Eligible to Participate does not have coverage under the Plan, irrespective of such Medical Emergency, unless Enrollment is completed prior to the expiration of such thirty-one (31) day period. In an emergency, the Participant is advised to immediately contact the Plan Administrator to determine whether Enrollment may be expedited prior to the expiration of such thirty-one (31) day period.

        iv. New employee D / New Seminarian D / Newly Incardinated Priest D

        IF: Start Date of Nov 2 (which date is the first working day of the month); Enrollment completed Nov 2

        THEN: Enrollment Date is Nov 1; Effective Date of Coverage is Nov 1; no Waiting Period

v. New employee E / New Seminarian E / Newly Incardinated Priest E

IF: Start Date of Nov 15; Enrollment completed Dec 10

THEN: Enrollment Date is Dec 10; Effective Date of Coverage is Dec 1; Waiting Period is from Nov 15 through Nov 30

c. **FAILURE TO ENROLL**. IF A PERSON ELIGIBLE TO PARTICIPATE DOES NOT ENROLL UNDER GENERAL ENROLLMENT OR DURING OPEN ENROLLMENT, IT SHALL BE CONSTRUED AS HIS/HER ELECTION TO WAIVE COVERAGE UNDER THE PLAN FOR HIM/HERSELF AND FOR ANY ELIGIBLE DEPENDENTS. ONLY IF SUCH INDIVIDUAL BECOMES ELIGIBLE FOR ENROLLMENT UNDER ANY OTHER ENROLLMENT OPTION MAY THE INDIVIDUAL SUBSEQUENTLY ENROLL HIM/HERSELF AND ANY ELIGIBLE DEPENDENTS IN THE PLAN.

2. **Open Enrollment.** Scheduling of an Open Enrollment period shall be at the sole discretion of the Plan Administrator, and shall not occur more often than annually. Nothing herein shall require the Plan Administrator to schedule an Open Enrollment period in any given year. During an annual open enrollment period, Persons Eligible to Participate will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Participants will be able to make changes in coverage for themselves and their eligible Dependents. Coverage Waiting Periods are waived during the annual open enrollment period for Participants and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan. If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- Participating Entities will give Persons Eligible to Participate written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of Coverage; and
- The Effective Date of Coverage will be July 1 following the annual open enrollment period.

3. **Special Enrollment** Special Enrollment is Enrollment that is not tied to a Start Date, but rather relates to an event in the life of a Person Eligible to Participate in the Plan. See the Section entitled Special Enrollment Provisions.

4. **Enrollment Per Medicaid & State Child Health Insurance Programs**. See next Section.

No Late Enrollment. There is no late enrollment option under any circumstances (meaning, there is no Enrollment Option if enrollment is not completed within the period specified under any other Enrollment Option available under the Plan). If a Person Eligible to Participate has not completed timely enrollment under any Enrollment Option but nonetheless seeks medical coverage, they must seek coverage through the federal mandated state exchanges, or such other resource as is available, until such time as an Enrollment Option becomes available to them under the Plan.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives each eligible person special enrollment rights if the person experiences a loss of other health coverage, a loss of eligibility for coverage under Medicaid or a state child health insurance plan, becomes eligible for premium assistance under Medicaid or a state child health insurance plan, or acquires a spouse or dependent through marriage, birth, adoption, or placement for adoption, as further explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Persons Eligible to Participate.

Under Special Enrollment, a Person Eligible to Participate is limited to either Enrolling him/herself and Eligible Dependents, or dropping coverage under the Plan altogether. A change in Plan Benefits Options is NOT available during Special Enrollment.

LOSS OF HEALTH COVERAGE

You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience a loss of other health coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions:

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

- You and/or Your Dependents stated in writing that You declined coverage due to coverage under another group health plan or health insurance policy; and

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

    - Continuation of Coverage and that coverage was exhausted; or
    - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
    - Terminated and no substitute coverage was offered; or
    - No longer receiving any monetary contribution toward the premium from the applicable Participating Entity.

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

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

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

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

- You failed to provide the required statement when declining coverage indicating that the reason coverage is being declined is due to coverage under another group health plan or health insurance policy.

LOSS OF ELIGIBILITY FOR COVERAGE UNDER A MEDICAID OR STATE CHILD HEALTH INSURANCE PLAN

You and/or Your Dependents may be Eligible for special enrollment in the Plan if You were covered under a Medicaid Plan or state Child health insurance Plan and You or Your Dependents' coverage was terminated due to loss of Eligibility, You must request coverage under this Plan within 60 days after the date of termination of such coverage.

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

A current Participant and his or her Dependents may be eligible for a special enrollment period if the Participant and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Participant must request coverage under this Plan within 60 days after the date the Participant and/or Dependents are determined to be eligible for such assistance.

ACQUISITION OF NEW DEPENDENT

Current Participants and their Dependents, Continuation of Coverage Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience certain changes in family status.

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

Special Considerations for a Newborn Child.

- For a newborn child of a Participant with Dependent coverage, coverage begins on the date of birth and remains in effect for thirty-one (31) days thereafter. To continue coverage beyond the initial thirty-one (31) days, the Plan must receive the completed enrollment documentation so as to process any required documents and any required premium within the thirty-one (31) days immediately following birth. Completed enrollment documentation includes full name, birth date, gender, social security number, and whether coverage is desired under the Participant's name or the Spouse's name.

- Charges for normal nursery care will be applied toward the Participant's coverage for the first thirty-one (31) days. If the newborn child is not Enrolled in the Plan within this period, there will be no payment from the Plan other than for normal nursery charges and Physician care charges incurred within the first thirty-one (31) days; the Participant is personally responsible for all other charges. If a Person Eligible to Participate is not enrolled in the Plan, and does not timely exercise Special Enrollment rights arising from the birth, then no birth expense, nursery care or expenses of the child shall be paid by the Plan.
- ollment rights arising from the birth, then no birth expense, nursery care or expenses of the child shall be paid by the Plan.
- llment rights arising from the birth, then no birth expense, nursery care or expenses of the child shall be paid by the Plan.

- If the newborn child has needs beyond normal nursery and Physician care after a normal birth, the newborn child must be Enrolled and any required premiums paid within the thirty-one (31) days immediately following the date of birth in order for the charges to be covered.

Note: If two Participants (e.g., a husband and a wife) are Enrolled under the Plan and the Participant who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other Participant with no suspension so long as coverage has been continuous.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

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

- In the case of marriage, on the date of the marriage (note that eligible individuals must submit a copy of the marriage certificate and their enrollment forms within 31 days of the date of the marriage in order for salary reductions to have preferred tax treatment from the date coverage begins); or

- In the case of a Dependent's birth, on the date of such birth (must provide copy of birth certificate); or

- In the case of a Dependent's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption (must provide state agency / court documentation confirming adoption, placement for adoption or placement of a Foster Child); or

- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the month following an approved request for coverage; or

- In the case of loss of coverage, the first day of the month following loss of coverage.

Timing of Special Enrollment. Special Enrollment must occur within thirty-one (31) days of the Special Enrollment Event. If Special Enrollment is not processed in this time period, the Special Enrollment option ceases to be available for that Special Enrollment Event.

All other Special Enrollment Events. Upon Enrollment, the Effective Date of Coverage for all other Special Enrollment Events is the first day of the month that is coincident with, or next following the Special Enrollment Event. The Timing Examples provided above under General Enrollment apply.

RELATION TO SECTION 125 CAFETERIA PLAN (FLEX PLAN)

This Plan shall also allow additional changes to enrollment due to change in status events as described in the Archdiocese of Denver Flexible Benefits Plan or the Diocese of Colorado Springs Flexible Benefits Plan, as applicable. This applies with respect to this Plan regardless of whether the employee elects to make their contributions for the self-funded medical benefits on a pre-tax or after-tax basis. Refer to Your Participating Entity's flexible benefits plan for more information.

TERMINATION

For information about continuing coverage, refer to the Continuation of Coverage section of this PD.

YOUR 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 toward 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 last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment; or
- The last day of the Plan Fiscal Year if You cancel coverage during an annual open enrollment period; or
- The end of the period for which You are eligible, as determined by the Participating Entity except as follows:
  - If You are temporarily absent from work/seminary during a period of Certified Disability or Educational Leave, or per a Sabbatical, see the “Certified Disability, Educational Leave, or Sabbatical” section of this Plan Document;
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan.

YOUR DEPENDENT'S COVERAGE

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

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The last day of the month in which Your coverage ends; or
- The last day of the month in which Your Dependent is no longer Your Spouse or does not meet the definition of Spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section (unless Your Dependent qualifies for extended Dependent coverage because her or she is Totally Disabled); or
- If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

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

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

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

- The last day of the Plan Fiscal Year if You cancel coverage during an annual open enrollment period; or

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

RESCISSION OF COVERAGE

As permitted by the ACA, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or an intentional misrepresentation of material fact. See the "Fraud" section of this PD for a description of certain actions that will be considered fraud.

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

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

REINSTATEMENT OF COVERAGE

See the "Eligibility" section for additional information applicable to rehired employees.

REFUND UPON TERMINATION; COLLECTION OF MONIES DUE

The Plan will refund that portion of the monthly premium contribution previously paid for coverage that was later rescinded; however, any claims paid will be offset by such amount. The Plan reserves the right to collect benefits paid to the Participant if claims paid are in excess of monthly premium payments.

CERTIFIED DISABILITY, EDUCATIONAL LEAVE, OR SABBATICAL

Coverage During Period of Certified Disability or Educational Leave of Absence. A Participant and his / her Eligible Dependent may remain eligible for coverage for a limited time if full time employment/seminary enrollment (as applicable) ceases due to a Certified Disability or an Educational Leave. This continuation will end as follows:

- Certified Disability Leave: The last day of the month an approved Short Term Disability ends and the Participant does not return to full time employment/seminary enrollment (as applicable). The Participant is responsible for his/her own portion of the monthly premium contribution.

- Educational Leave: If a Participant has coverage at the time that Educational Leave commences:

  - the Participant and their Dependent may continue coverage under the Plan for the duration of the Educational Leave, which period shall not exceed six (6) months;

  - the Participant is responsible for the entirety of the monthly premium payment due (both Participant's portion and the employer/sponsor portion);

  - the monthly premium payment is due the first day of the month following the month in which the Educational Leave commences, to be received by the Plan Administrator no later than the first of each month thereafter.

If coverage is continued under this section, coverage will be that which was in force on the last day worked/classes attended (as applicable). However, if benefits reduce for others in the same class of eligible individuals, such benefits will also reduce for the continued person. A change in Plan Options is NOT available upon electing Continuation of Benefits. Note: Educational Leave is not Sabbatical Leave. See next section for information on Sabbatical Leave.

Coverage During Sabbatical Leave. A Participant and his / her Eligible Dependent shall remain eligible for coverage if the Participant is granted Sabbatical Leave by their Participating Entity to promote their intellectual and spiritual growth. If a Participant has coverage at the time that Sabbatical Leave commences:

- the Participant and his / her Dependent may continue coverage under the Plan for the duration of the Sabbatical Leave, which leave period shall not exceed twelve (12) months;

- the Participant shall continue to be responsible for the monthly premium payment portion he/she was responsible for just prior to the Sabbatical Leave, and the Participating Entity shall continue to be responsible for the employer's portion of the monthly premium payment;

- the monthly premium payment is due the first day of the month following the month in which the Sabbatical Leave commences, to be received by the Plan Administrator no later than the first of each month thereafter.

If coverage is continued under this section, coverage will be that which was in force on the last day prior to the Sabbatical Leave. However, if benefits reduce for others in the same class of eligible individuals, such benefits will also reduce for the continued person. Note: Sabbatical Leave is not Educational Leave. See previous section for information on Educational Leave.

CONTINUATION OF COVERAGE

Note: The Plan is intended to be a "church plan" as defined in Code Section 414(e) and Section 3(33) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan is not subject to Title I of ERISA, including Part 6 of Title I which provides for continuation of health care coverage upon the occurrence of certain events. To the extent that any of the continuation of coverage provisions described in this notice are identical to the requirements of Part 6 of ERISA Title I, the inclusion of such provisions reflects the unilateral decision of the Archdiocese of Denver Welfare Benefits Trust to do so, and the Archdiocese of Denver Welfare Benefits Trust reserves the right to modify the continuation of coverage provisions of the Plan in the future, as long as the provisions so modified meet the requirements of other applicable law.

The Continuation of Coverage Administrator for this Plan is: UMR

Important: Read this entire provision to understand a Covered Person's Continuation of Coverage rights and obligations.

This summary generally explains Continuation of Coverage, when it may become available to You and Your covered Dependents, and what You and Your covered Dependents need to do to protect the right to receive it. When You become eligible for Continuation of Coverage, You may also become eligible for other coverage options that may cost less than Continuation of Coverage. This section provides a general notice of a Covered Person's rights under Continuation of Coverage, The Plan Administrator or the Continuation of Coverage Administrator will provide additional information to You or Your covered 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 coverage through 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 does not accept Late Enrollees.

INTRODUCTION

Qualified Beneficiaries (defined below) have the right to continue their health care benefits beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the Continuation of 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, the Plan must offer Continuation of Coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under Continuation of Coverage.

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

CONTINUATION OF COVERAGE FOR QUALIFIED BENEFICIARIES

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

If You are a Participant, You will become a Qualified Beneficiary if You lose coverage under the Plan because 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 Continuation of Coverage may be extended. See the section below entitled "The Right to Extend the Length of Continuation of Coverage" for more information.)

The Spouse of a Participant will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

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

The Dependent Children of a Participant will become Qualified Beneficiaries if they lose coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The parent- Participant dies	up to 36 months
• The parent- Participant's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent- Participant's hours of employment are reduced	up to 18 months
• The parent- Participant 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 loses eligibility for coverage under the plan as a Dependent	up to 36 months

Note: A Spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provisions of the Plan apply to enrollees during continuation coverage. A Dependent who is not covered under the Plan at the time of a subsequent Qualifying Event, other than a newborn or newly adopted Child who is acquired and enrolled after the original Qualifying Event, is not eligible as a Qualified Beneficiary.

CONTINUATION OF COVERAGE NOTICE PROCEDURES

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

In order to be eligible to receive Continuation of Coverage, Participants and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Participant and Spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the Plan Administrator. Follow the rules described in this procedure when providing notice to the administrators, whether to the Plan Administrator, Your Participating Entity, or to the Continuation of Coverage Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the Continuation of Coverage Administrator is available upon request):

- The Qualified Beneficiary's name, current address, and complete phone number,
- The group number and the name of the Participant's employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

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

UMR
CONTINUATION OF COVERAGE ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206
Phone Number: (800) 207-1824

For purposes of the deadlines described in this 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 to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or Continuation of Coverage Administrator.

CONTINUATION OF COVERAGE NOTICE REQUIREMENTS AND ELECTION PROCESS

PARTICIPATING ENTITY OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your Participating Entity will give notice to the Continuation of Coverage Administrator when coverage terminates due to the Participant's termination of employment or reduction in hours, Participant's departure from seminary, Participant's death, or Participant becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). A Participating Entity will notify the Continuation of Coverage Administrator within 30 calendar days of when one of these events occurs.

PARTICIPANT OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

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

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

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

The Continuation of Coverage 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 Participating Entity, the Participant, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

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

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

A Qualified Beneficiary must notify the Continuation of Coverage 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 the Qualified Beneficiary does not choose Continuation of Coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

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

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

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the Participating Entity and Participant contributions. This cost 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). The cost of continuation coverage is subject to change at least once per year.

If the Plan Administrator offers an annual open enrollment opportunity, each Qualified Beneficiary will have the same options under Continuation of Coverage as current Participants (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 Continuation of Coverage 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 coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

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

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

If the Continuation of Coverage Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the Continuation of Coverage Administrator will provide a notice to the Qualified Beneficiary and allow him or her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(ies) will lose coverage under the Plan in accordance with the Plan language above.

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

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON CONTINUATION OF COVERAGE

Always keep the Continuation of Coverage 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 Continuation of Coverage Administrator may cause You or Your Dependents to lose important rights under Continuation of Coverage.

In addition, written notice to the Continuation of Coverage Administrator is required within 30 calendar days of the date any one of the following events occurs:

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

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

- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

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

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

LENGTH OF CONTINUATION COVERAGE

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

- <u>For Participant and Dependents</u>: 18 months from the Qualifying Event if due to the Participant's termination of employment or reduction of work hours. (If a Participant enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered Spouse and Dependent Children will be entitled to Continuation of Coverage for up to the greater of 18 months from the Participant'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:

  - The Participant's death.
  - The Participant's divorce or legal separation.
  - The former Participant is enrolled in Medicare.
  - A Dependent Child's loss of eligibility as a Dependent as defined by the Plan.

THE RIGHT TO EXTEND THE LENGTH OF CONTINUATION OF COVERAGE

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

Social Security Disability Determination (For Participants and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month Continuation of Coverage continuation period, for a total maximum of 29 months of Continuation of Coverage, 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, Continuation of Coverage continuation coverage. This extension will not apply if the original Continuation of Coverage continuation was for 36 months.

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

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

- The date of the Social Security Administration 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 Continuation of Coverage Administrator of the disability by receiving this Plan Description or the General Continuation of Coverage Notice.

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

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

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

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

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

COVERAGE OPTIONS OTHER THAN CONTINUATION OF 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 Continuation of Coverage. You can learn more about many of these options at www.healthcare.gov.

EARLY TERMINATION OF CONTINUATION OF COVERAGE

Continuation of Coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The Trust ceases to maintain a group health plan for any Participants. (Note that if the Trust terminates the group health plan under which the Qualified Beneficiary is covered, but still maintains another group health plan for other, similarly situated Participants, the Qualified Beneficiary will be offered Continuation of 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 within the timeframe expressed in the Continuation of Coverage regulations.

- After electing Continuation of Coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.

- After electing Continuation of 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 Continuation of Coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

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

At the time of a Continuation of Coverage Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to Continuation of Coverage 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 Provision section for further details. The second option is to elect Continuation of Coverage. If Continuation of Coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the Continuation of Coverage continuation period. If the continuation coverage is not exhausted and maintained for the duration of the Continuation of Coverage 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 since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After Continuation of 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 a Qualifying Event. A Qualified Beneficiary may be a Participant, the Spouse of a Participant, or the Dependent Child of a Participant. This includes a Child who is born to or Placed for Adoption with a Participant during the Participant's Continuation of 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 Participant.
- Voluntary or involuntary termination of the Participant's employment (other than for gross misconduct).
- A Participant permanently leaving seminary.
- A reduction in work hours of the Participant.
- Divorce or legal separation of the Participant from his/her Spouse. (Also, if Participant 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 Continuation of Coverage Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then Continuation of Coverage may be available for the period after the divorce or legal separation.)
- The former Participant becomes enrolled in Medicare.
- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, partial Loss of Coverage, an increase in Participant cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event, but 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 Continuation of Coverage rights.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your Continuation of Coverage rights should be addressed to the contacts identified below. For more information about the Marketplace, visit www.HealthCare.gov.

The Plan Administrator:
THE ARCHDIOCESE OF DENVER MANAGEMENT CORPORATION
ATTN: DIRECTOR, OFFICE OF HUMAN RESOURCES
1300 S STEELE ST
DENVER CO 80210

The Continuation of Coverage Administrator:
UMR CONTINUATION OF COVERAGE ADMINISTRATION
PO BOX 1206
WAUSAU WI 54402-1206

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer Continuation of Coverage like health care continuation coverage to covered employees who take a leave of absence for service in the armed service if the absence for military duty would result in a loss of coverage.

Participants on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Participants on leaves of absence or furloughs. If a Participating Entity has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Participants on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (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 Participant fails to return to or reapply for employment within the time allowed by USERRA.

USERRA coverage may be terminated early if a Participant fails to timely pay required premiums or loses his /her rights under USERRA as a result of a dishonorable discharge or other conduct set forth in USERRA.

USERRA NOTICE AND ELECTION

A Participant or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the proper Participating Entity that the Participant intends to leave his/her position with the Participating Entity and perform service in the uniformed services. A Participant should provide notice as far in advance as is reasonable under the circumstances. The Participant is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

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

PAYMENT

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

EXTENDED COVERAGE RUNS CONCURRENTLY

Participants and their Dependents may be eligible for both Continuation of Coverage and USERRA at the same time. Election of either the Continuation of Coverage or USERRA extension by a Participant on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Participant will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed to elect Continuation of Coverage extension only 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 Co-pay, 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 Co-pay, 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 Co-pay, 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 Co-pay, 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 Co-pay, 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 Co-pay, 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 Co-pay, 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

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

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

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

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

  ARCHDIOCESE OF DENVER WELFARE BENEFITS TRUST

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

The program for Transplant Services at Designated Transplant Facilities is:

OptumHealth

EXCEPTIONS TO THE PROVIDER NETWORK RATES

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 the Usual and Customary charge limitations. The following exceptions may apply:

- Covered 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 (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist will be payable at the In-Network level of benefits when services are referred by an In-Network Physician, even if the provider is 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 there is no In-Network provider, or no In-Network provider is willing or able to provide the necessary service(s) to the Covered Person within a 100-mile radius of the Covered Person's residence, the Covered Person may be eligible to receive In-Network benefits from an Out-of-Network provider. In this situation, Your In-Network Physician will notify the Claims Administrator, who will work with You and Your In-Network Physician to coordinate care through an Out-of-Network provider.

Provider Directory Information

Each Participant, Continuation of Coverage participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The Participant should share this document with other covered individuals in his or her household. If a covered Spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the Spouse or other covered Dependents.

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. Retiree-only plans are not subject to the Continuity of Care requirements.

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 or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this PD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent International Classification of Diseases (ICD) or 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.

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

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. **Acupuncture Treatment.**

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

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

5. **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.

6. **Anesthetics and Their Administration.**

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

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

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

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

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

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

   If ABA therapy meets Medical Necessity, frequency and duration will be subject to current UMR guidelines (for example, ABA treatment up to 25 hours per week for 3-6 months). Treatment plans specific to ABA therapy with goals-progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued Medical Necessity.

   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).

10. **Breast Reductions** if Medically Necessary.

11. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (see the Glossary of Terms) and when needed as a result of an Illness or Injury.

12. **Cardiac Rehabilitation** programs (when Medically Necessary), if referred by a Physician, for patients who have certain cardiac conditions including, but not limited to, the following:

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

    Covered services include:

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

13. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

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

15. **Cleft Palate and Cleft Lip,** including Medically Necessary oral surgery and pre-graft palatal expanders.

16. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at an OptumHealth 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.

17. **Contraceptives:** This Plan provides benefits for Prescription contraceptives and the related office visit only when Medically Necessary but specifically excludes benefits coverage of Prescription contraceptives if prescribed for the prevention of pregnancy. Covered prescription contraceptives that a Covered Person self-administers will be processed under the Prescription Drug Benefits section of this document. Covered prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this PD.

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

19. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), including implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
    - Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if Medically Necessary.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

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

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

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

    - The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to the growth of the person or if changes to the person's medical condition require a different product, as determined by the Plan.

- If the equipment is purchased, benefits may be payable for subsequent repairs including batteries, or replacement only if required:
  - due to the growth or development of a Dependent Child;
  - 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.

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

24. **Extended Care Facility Services** for both mental and physical health diagnoses. Charges will be paid under the applicable diagnostic code. The following services are covered:

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

25. **Eye Refractions** if related to a covered medical condition.

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

    - Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
    - Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

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

28. **Genetic Testing** when Medically Necessary (see below).

    Genetic testing MUST meet the following requirements:

    The test must not be considered Experimental, Investigational, or Unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person. In some cases, testing may be accompanied with pre-test and post-test counseling.

    Genetic testing must also meet at least one of the following:

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

Generally, genetic testing is not covered for:

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

29. **Hearing Services** including exams, tests, services, and supplies to diagnose and treat a medical condition.

30. **Home Health Care Services:** (Refer to the Home Health Care Benefits section of this PD.)

31. **Home Infusion Therapy.**

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

- **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required 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,** which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician.
- **Bereavement Counseling:** benefits are allowed for Covered Person's only, in the event of the death of an immediate family member, and the charges for which are bundled with other hospice charges. Counseling services must be provided by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within three months of death.

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

33. **Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers).** The following services are covered:

- 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 Out-of-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.

Plan intent is that Emergency Room-to-Inpatient Admissions be processed at the Tier 1 benefit level, until a Covered Person is stabilized. Once a Covered Person is stabilized, the Covered Person is to be moved to a Centura or In-Network facility, dependent on plan design, and claims to process at the tier of that facility.

If the Covered Person is stabilized and chooses not to be moved, then claims will be split and the length of stay in which the Covered Person is stabilized are to process at the tier of that facility, even if not eligible for coverage if at an Out-Of-Network facility, dependent on plan design.

Note: The claims discovered during the impact research will be adjusted to process at the Tier 1 benefit level, but will be grandfathered so as not to be subject to the stabilization provision.

34. **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.

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

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

    Infertility Treatment does not include Genetic Testing.

37. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits.

38. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this PD.

39. **Massage Therapy.** (See Therapy Services below.)

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

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

41. **Medical and/or Routine Services Provided in a Foreign Country**, except that no coverage is provided if the sole purpose of travel to that country is to obtain medical services and/or supplies.

42. **Mental Health Treatment.** (Refer to Mental Health Benefits section of this PD).

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

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

    - Nutritional counseling by registered dieticians or other Qualified Providers.

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

45. **Natural Family Planning And Associated Supplies.** Associated supplies include thermometers, charts/stamps, course manuals, subscriptions to NFP related computer applications (apps), fertility monitors, test strips, and other NFP related tracking/support supplies.

46. **Nursery and Newborn Expenses, Including Circumcision,** are covered for the following Children of the Participant or covered Spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

47. **Nutritional Counseling** if Medically Necessary.

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

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

50. **Oral Surgery** includes:

    - Excision of partially or completely impacted teeth.
    - 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 of the mouth, and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitis.
    - Incision of accessory sinuses, salivary glands, or ducts.
    - Excision of exostosis of jaws and hard palate.

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

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

53. **Oxygen and Its Administration.**

54. **Pharmacological Medical Case Management** (medication management and lab charges).

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

56. **Physician Services** for covered benefits.

57. **Pre-Admission Testing** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

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

59. **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, and have been proven to have a beneficial effect on health outcomes.

60. **Private Duty Nursing Services** when Outpatient care is required and Medically Necessary 24 hours per day. Coverage does not include Inpatient private duty nursing services unless Medically Necessary and the Hospital's intensive care unit is filled or the Hospital has no intensive care unit.

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

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

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

62. **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 (e.g., 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 Veterans Administration (VA);
    - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
    - The Department of Veterans Affairs, the DOD, 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 NIH; 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 as been approved by all relevant Institutional Review Boards (IRBs) before participants are enrolled in the trial. The Plan 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.

63. **Radiation Therapy and Chemotherapy.**

64. **Radiology and Interpretation Charges.**

65. **Reconstructive Surgery** includes:

- Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, 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 that 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 a bodily function that has been impaired by a congenital Illness or anomaly, by an Accident, or from an infection or other disease of the involved part.

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

67. **Second Surgical Opinion** if given by a board-certified Specialist in the medical field related 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.

68. **Sleep Disorders** if Medically Necessary.

69. **Sleep Studies.**

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

71. **Spiritual Care** is the aspect of health care that attends to spiritual and religious needs brought on by an Illness or Injury through counseling.**.**

72. **Substance Use Disorder Services.** (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this PD.)

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

- If an assistant surgeon is required, the assistant surgeon's covered change will not exceed 20% of the allowance for the primary procedure performed. For in-network providers, the assistant surgeon's allowable amount will be determined per the network contract.
- If bilateral or Multiple Surgical Procedures are performed by one surgeon, benefits will be determined based on the Usual and Customary charge that is allowed for the primary procedure; 50% of the Usual and Customary charge will be allowed for each additional procedure performed through the same incision; and 70% of Usual and Customary charge will be allowed for each additional procedure performed through a separate incision.
- If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Usual and Customary charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Usual and Customary percentage allowed for that procedure.

74. **Telehealth**. Consultations made by a Covered Person to a Physician.

75. **Telemedicine**. (Refer to the Teladoc Services section of this PD for more details.)

76. **Temporomandibular Joint Disorder (TMJ) Services** include:

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

77. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.
- **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if performed in conjunction with physical / occupational therapy by providers acting within the scope of their license.
- **Massage therapy** by a Qualified chiropractor, a Qualified massage therapist (MT), a Qualified physical therapist (PT), or other Qualified Provider, if applicable.
- **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 applicable, including 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. The Plan allows coverage for the treatment of disorders such as speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, or a Congenital Anomaly. The Plan will pay benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular Accident.

78. **Transplant Services.** (Refer to Transplant section of this PD.)

79. **Urgent Care Facility** as shown in the Schedule of Benefits of this PD.

80. **Vision Care Services.** (Refer to Vision Care section of this PD.)

81. **Walk-In Retail Health Clinics:** Charges associated with medical services provided at Walk-In Retail Health Clinics.

82. **Wigs (Cranial Prostheses), Toupees, and Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.

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

TELADOC SERVICES

Note: Teladoc Services described below are subject to state availability. Access to telephonic or video-based consultations may be restricted in some states.

This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses.

Teladoc may be used:

- When immediate care is needed.
- When considering the emergency room or urgent care center for non-Emergency issues.
- When You are on vacation or on a business trip.

Teladoc can be used for the following types of conditions:

- General medicine, including, but not limited to:
  - Colds and flu
  - Allergies
  - Bronchitis
  - Pink eye
  - Upper respiratory infections
- A refill of a recurring Prescription.
- Pediatric care.
- Non-Emergency medical assistance.

In order to obtain this benefit, a Covered Person must complete a medical history disclosure form that will serve as an electronic medical record for consulting Physicians. This form can be completed via the Teladoc website, via the call center, or via the Teladoc mobile app. Once enrolled, a Covered Person may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Physician. A Physician will then return the Covered Person's phone call. If a Covered Person requests a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a Prescription. The Prescription will be called in to a pharmacy of the Covered Person's choice. Benefits for this service are shown in the Schedule of Benefits.

Teladoc may not be used for:

- Drug Enforcement Agency-controlled Prescriptions.
- Charges for telephone or online consultations with Physicians and/or other providers who are not contracted through Teladoc.

Dermatology Services Program

In addition to receiving care for general medical conditions, Covered Persons may receive access to dermatology services, as described below.

Dermatologists provide dermatology consultations to Covered Persons through an online message center using store-and-forward technology in the dermatology service area. The dermatology program offers Covered Persons the ability to upload photographs of their dermatological conditions to licensed dermatologists, who provide treatment and prescription medication, when appropriate. The dermatologists are selected and engaged to provide dermatological assessments in accordance with standard dermatology protocols and guidelines that are tailored to the telehealth industry.
ols and guidelines that are tailored to the telehealth industry.

In order to receive dermatology consultations, the Covered Person must have completed Teladoc's requirement for access to the general medicine program, including the medical history disclosure form. The Covered Person must also complete a comprehensive Dermatology Intake Form prior to receiving a dermatology consultation. The Dermatology Intake Form consists of a Dermatology History section and an intake form for the condition for which the Covered Person is seeking treatment describing the area of concern. This medical history and intake form may be completed either online or by telephone with a designated dermatology representative. Additionally, the Covered Person must upload at least three images of their condition prior to communicating with a dermatologist. If the Covered Person fails to complete the Dermatology Intake Form or upload the required number of images, the Covered Person will not have access to the dermatologists.

Covered Persons will be allowed to request more than one dermatology consultation at any given time. Dermatology consultations are not intended to be provided in Emergency situations.

Initial Consultation: The Covered Person will be required to upload a minimum of three images and a maximum of five images for the dermatologist to review. A dermatologist will respond to the Covered Person's consultation submission via the Teladoc Message Center within two business days of such submission. The dermatologist will either:

- determine that no additional information is required and provide a diagnosis and prescription, if appropriate; or
- request additional information from the Covered Person before making a diagnosis.

Covered Person Follow-Up: The Covered Person will have seven days after diagnosis to respond to the dermatologist with follow-up questions via the message center. The Covered Person will be able to respond only once and may upload up to five additional images in the response. The Covered Person will not be charged for a one-time follow-up.

Subsequent Consultations: A Covered Person will have the option of selecting the same dermatologist with whom they had a prior consultation or with a new dermatologist licensed in their state.

Behavioral Health Program

The Behavioral Health Program includes access to behavioral health providers who provide behavioral health consultations to Covered Persons by telephone or video conference. The Behavioral Health Program offers Covered Persons ongoing access to behavioral diagnostic services, talk therapy, and prescription medication management, when appropriate. The behavioral health providers are selected and engaged to provide behavioral health clinical intake assessments in accordance with behavioral health protocols and guidelines that are tailored to the telehealth industry.

Behavioral Health Consultations: In order for a Covered Person to receive a behavioral health consultation under this program, the Covered Person must complete a Medical History Disclosure and an assessment that is specific to the Behavioral Health Program. This disclosure may be completed either online or by telephone with a designated Behavioral Health Program representative. In addition, the Covered Person must also agree to Teladoc's Informed Patient Consent and Release Form confirming an understanding that the behavioral health provider is not obligated to accept the Covered Person as a patient. If the Covered Person fails to complete the Medical History Disclosure, the Covered Person will not have access to the behavioral health providers through the Behavioral Health Program.

Scheduling: Teladoc will provide the Covered Person with information identifying each behavioral health provider's licensure, specialties, gender, and language, and will provide sufficient biographical information on each behavioral health provider to allow the Covered Person to choose the provider from whom he or she wishes to receive treatment. The Covered Person may schedule consultations through either Teladoc's website or the mobile platform. When scheduling a subsequent consultation, the Covered Person may choose to receive the consultation from the same provider or from a different behavioral health provider. There are no limitations on the number of behavioral health consultations a Covered Person may receive under the Behavioral Health Program.

Individual Sessions: The initial behavioral health consultation is expected to be 45 minutes in length, on average followed by subsequent psychiatric visits that will be shorter in length. At the beginning of the behavioral health consultation, the Covered Person will be required to complete a brief intake assessment before proceeding with the session. A behavioral health provider may determine that the treatment of a Covered Person's particular behavioral health issue would be managed more appropriately through in-person therapy. In such a case, the behavioral health provider will encourage the Covered Person to make an appointment for an in-person visit.

Clarifications: Unlike the consultations provided under the general medicine program, the behavioral health consultations under the Behavioral Health Program:

- Are not accessible 24 hours per day, 365 days per year. Rather, a Covered Person must schedule a behavioral health consultation with a behavioral health provider and the consultation must occur within a time period for which the behavioral health provider is scheduled to support the Behavioral Health Program.
- Are not intended to be cross-coverage consultations. Rather, the Behavioral Health Program is designed to make behavioral health providers available by telephone or video conference even when another behavioral health counselor is available to the Covered Person for an in-person visit.
- Are not intended to be provided in Emergency situations.
- Are not available for Teladoc therapy for Covered Persons under the age of 13.
- Are not available for Teladoc psychiatry for Covered Persons under the age of 18.

Behavioral Health Service Area: The Behavioral Health Program is currently not available in the following states: Oklahoma and South Dakota. Teladoc may suspend or discontinue providing the Behavioral Health Program in any jurisdiction in which the program is currently offered in response to regulatory changes or interpretations affecting the practice of behavioral health, Telemedicine, and/or cross-coverage consultations in the applicable jurisdiction.

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 PD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed 4 hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a Qualified therapist or other Qualified Provider, if applicable.
- Medical supplies, drugs, laboratory services, or medication prescribed by a Physician.

A Home Health Care Visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a 4-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

EXCLUSIONS

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

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

TRANSPLANT BENEFITS

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

DEFINITIONS

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

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

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

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation, and the storage of human organ and tissue that 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).

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a 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 as applicable.

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

COVERED EXPENSES

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

If a Covered Person requires a transplant, including a 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. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

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

Benefits are payable for the following transplant types:

- Kidney.
- Kidney and pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart and 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 transplant facility, the Plan will allow him or her 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 or supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient and / or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person and / or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility, including:
  - Airfare.
  - Tolls and parking fees.
  - Gas/mileage.
- Lodging at or near the transplant facility, including:
  - Apartment rental.
  - Hotel rental.
  - Applicable tax.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day may be considered taxable income under the Internal Revenue Code.

Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will pay travel and housing benefits for a non-covered living donor only after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

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

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational, or Unproven unless covered under a Qualifying Clinical Trial.
- 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 National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and home delivery service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Benefits (see the "Definitions" subsection at the end of this "Prescription Drug Benefits" section).

Prescription Drug Benefit Highlights

Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card) – Network Pharmacy

You must either show Your ID card at the time You obtain Your Prescription Drug at a Network Pharmacy or provide the Network Pharmacy with identifying information that can be verified by Optum Rx during regular business hours.

If You do not show Your ID card or provide verifiable information at a Network Pharmacy, You will be required to pay the Usual and Customary Charge for the Prescription Drug at the Pharmacy.

Benefit Levels

Benefits are available for Outpatient Prescription Drugs that are considered a Covered Expense.

The Plan pays benefits at different levels for tier 1, tier 2, and, if applicable, tier 3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug may change periodically, as frequently as monthly, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, You may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, for the most current information, You can visit www.umr.com, and navigate to the Pharmacy section, or call Optum Rx at 877-559-2955.

Each tier is assigned a Co-pay or Participation, which is the amount You pay when You visit the Pharmacy or order Your medications through home delivery. Your Co-pay or Participation will also depend on whether or not You visit the Pharmacy or use the home delivery service; see the Prescription Schedule of Benefits for further details. Here is how the tier system works:

- Tier 1 is usually Your lowest Co-pay or Participation option. For the lowest out-of-pocket expense, You should consider tier 1 drugs if You and Your Physician decide they are appropriate for Your treatment.

- Tier 2 is Your middle Co-pay or Participation option. Consider a tier 2 drug if no tier 1 drug is available to treat Your condition.

- Tier 3, if applicable, is Your highest Co-pay or Participation option. The drugs in tier 3 are usually more costly. Sometimes there are alternatives available in tier 1 or tier 2.

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

- The applicable Co-pay, Participation, or Deductible amount;
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- The Prescription Drug charge that Optum Rx agreed to pay the Network Pharmacy.

For Prescription Drugs from a home delivery Network Pharmacy, You are responsible for paying the lower of:

- The applicable Co-pay, Participation, or Deductible amount; or
- The Prescription Drug Charge for that particular Prescription Drug.

Retail

The Plan has a network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by visiting www.umr.com, and navigating to the Pharmacy section, or call Optum Rx at 877-559-2955.

To obtain Your Prescription from a retail pharmacy, simply present Your ID card and pay the Co-pay, Participation, or Deductible amount. The Plan pays benefits for certain covered Prescription Drugs as written by a Physician and in accordance with the Plan.

Note: Pharmacy Benefits apply only if Your Prescription is for a Covered Expense, and not for Experimental, Investigational, or Unproven Services. Otherwise, You are responsible for paying 100% of the cost.

Home Delivery

The home delivery service may allow You to purchase up to a 90-day supply of a covered maintenance drug through the mail. Maintenance drugs help in the treatment of chronic Illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the home delivery service, all You need to do is complete a patient profile and enclose Your Prescription order. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after Your order is received. If You need a patient profile form, or if You have any questions, You can reach Optum Rx at 877-559-2955.

The Plan pays home delivery benefits for certain covered Prescription Drugs as written by a Physician and in accordance with the Plan.

You may be required to fill an initial Prescription Drug order and obtain one or more refills through a retail Pharmacy prior to using a home delivery Network Pharmacy.

Note: To maximize Your benefit, ask Your Physician to write Your Prescription order or refill for a 90-day supply, with refills when appropriate (and not a 30-day supply with three refills). You will be charged a home delivery Co-pay, Participation, or Deductible amount for any Prescription order or refill if You use the home delivery service, regardless of the number of days' supply that is written on the order.

Designated Pharmacy

If You require certain Prescription Drugs, Optum Rx may direct You to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Please see the Definitions in this section for the definition of Designated Pharmacy.

Want to lower Your out-of-pocket Prescription Drug costs?

Consider tier 1 Prescription Drugs, if You and Your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

Optum Rx Pharmacy and Therapeutics (P&T) Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the P&T Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- Evaluations of the place in therapy;
- Relative safety and efficacy; and
- Whether supply limits or notification requirements should apply.

Economic factors may include:

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

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

The P&T Committee may periodically change the placement of a Prescription Drug among the tiers. These changes may occur as frequently as monthly and may occur without prior notice to You.

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

Prescription Drug List (PDL)

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

Prior Authorization Requirements

Before certain Prescription Drugs are dispensed to You, it is the responsibility of Your Physician, Your pharmacist, or You to obtain prior authorization. Optum Rx will determine if the Prescription Drug, in accordance with Your Plan's approved guidelines, is both:

- A Covered Expense as defined by the Plan; and
- Not Experimental, Investigational, or Unproven.

Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or You are responsible for obtaining prior authorization from Optum Rx.

Non-Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a non-Network Pharmacy, You or Your Physician is responsible for obtaining prior authorization from Optum Rx as required.

To determine if a Prescription Drug requires prior authorization, You can visit www.umr.com, and navigate to the Pharmacy section, or call Optum Rx at 877-559-2955. The Prescription Drugs requiring prior authorization are subject to periodic review and modification.

Benefits may not be available for the Prescription Drug after Optum Rx reviews the documentation provided and determines that the Prescription Drug is not a covered health service or it is an Experimental, Investigational, or Unproven service.

We may also require prior authorization for certain programs that may have specific requirements for participation and/or activation of an enhanced level of benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation, or activation requirements associated with such programs through the Internet at www.umr.com, and navigating to the Pharmacy section, or call Optum Rx at 877-559-2955.

Limitation on Selection of Pharmacies

If Optum Rx determines that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Network Pharmacies may be limited. If this happens, You may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the designated single Network Pharmacy.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per Prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit www.umr.com, and navigate to the Pharmacy section, or call Optum Rx at 877-559-2955. Whether or not a Prescription Drug has a supply limit is subject to Optum Rx's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan and Optum Rx have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per Prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name drug may change. As a result, Your Co-pay, Participation, or Deductible amount may change. You will pay the amount applicable for the tier to which the Prescription Drug is assigned.

Special Programs

The Trust and Optum Rx may have certain programs in which You may receive an enhanced or reduced benefit based on Your actions such as adherence to or compliance with medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.umr.com, and navigating to the Pharmacy section, or call Optum Rx at 877-559-2955.

Rebates and Other Discounts

Optum Rx and The Trust may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that You purchase prior to meeting any applicable Deductible. As determined by us, we may pass a portion of these rebates on to You. When rebates are passed on to You, they may be taken into account in determining Your Co-payment and/or Participation.

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

COVERED BENEFITS - What the Prescription Drug Benefits Section Will Cover

The following are considered Covered Expenses:

- **Prescription products that:**

  - Are necessary for the care and treatment of an Illness or Injury and are prescribed by a duly licensed medical professional; and
  - Can be obtained only by Prescription and are dispensed in a container labeled "Rx only" or with similar language; and
  - Are any of the following non-prescription products prescribed by a duly licensed medical professional:
    - Compounded medications of which at least one ingredient is an FDA Prescription Drug;
    - Any other medications that, due to state law, may be dispensed only when prescribed by a duly licensed medical professional; and
    - In an amount not to exceed the day's supply outlined in the Prescription Schedule of Benefits.

- **Prescription Drugs lost as a direct result of a natural disaster.** Covered Persons will be given the opportunity to prove that Prescription Drugs otherwise considered Covered Expenses under this Plan were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (homeowner's, property, etc.).

- **Home Delivery Prescriptions.** The Plan will pay for Covered Expenses Incurred by a Covered Person for Prescription products dispensed through the home delivery pharmacy identified by Optum Rx. Prescription products may be ordered by mail with a Co-pay from the Covered Person for each Prescription or refill. The Co-pay is shown on the Prescription Schedule of Benefits. By law, Prescription products may not be mailed to a Covered Person outside the United States.

- **Diabetic Supplies.** Some diabetic supplies may be covered.

- **Vaccines.** Some vaccines may be covered and may have limitations depending on whether the vaccine is administered in a pharmacy or a clinic.

Covered Expenses apply only to certain Prescription Drugs and supplies. You can visit www.umr.com, and navigate to the Pharmacy section, or call Optum Rx at 877-559-2955, for information on which specific Prescription Drugs and supplies are covered.

EXCLUSIONS - What the Prescription Benefits Section of this Plan Will Not Cover

The following exclusions apply.

When an exclusion applies to only certain Prescription Drugs, You can visit www.umr.com, and navigate to the Pharmacy section, or call Optum Rx at 877-559-2955, for information on which Prescription Drugs are excluded.

Excluded medications are:

- Any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment for benefits are received, except as otherwise provided by law;
- Pharmaceutical products for which benefits are provided in the medical (not in the Prescription Drug Benefits) portion of the Plan;
- Available over-the-counter drugs that do not require a Prescription order or refill by federal or state law before being dispensed, unless the Plan has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription order or refill from a Physician;

- Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent;
- Certain Prescription Drugs that the Plan has determined are Therapeutically Equivalent to an over-the-counter drug. The Plan may decide, at any time, to reinstate benefits for a Prescription Drug that was previously excluded under this provision;
- Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription order or refill. Compounded drugs that may be available as a similar, commercially available Prescription Drug;
- Compound drugs that contain non-FDA approved bulk ingredients, available as similar commercial Prescription Drugs, and contain non-covered over-the-counter products;
- Dispensed outside of the United States, except in an Emergency;
- Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
- Medications where the amount dispensed (days' supply or quantity limit) that exceeds the supply limit;
- Medications where the amount dispensed (days' supply or quantity limit) that is less than the minimum supply limit;
- Certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
- Prescribed, dispensed, or intended for use during an Inpatient stay;
- Prescription Drugs, including New Prescription Drug Products or new dosage forms, that Optum Rx and determines do not meet the definition of a Covered Expense;
- Used for conditions and/or at dosages determined to be Experimental, Investigational, or Unproven, unless Optum Rx and the Trust have agreed to cover an Experimental, Investigational, or Unproven treatment, as defined in the Glossary of Terms;
- Most Vaccines;
- Vitamins, except for the following, which require a Prescription:
  - Prenatal vitamins;
  - Vitamins with fluoride; and
  - Single-entity vitamins.

DEFINITIONS

Brand-name means a Prescription Drug that is either:

- Manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- Identified by Optum Rx as a Brand-name drug based on available data resources, including, but not limited to, Medi-Span, which classifies drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "Brand-name" by the manufacturer, the pharmacy, or Your Physician may not be classified as Brand-name by Optum Rx.

Co-payment (or Co-pay) means the amount You are required to pay for certain Prescription Drugs.

Designated Pharmacy means a pharmacy that has entered into an agreement with Optum Rx, or with an organization contracting on its behalf, to provide specific Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic means a Prescription Drug that is either:

- Chemically equivalent to a Brand-name drug; or
- Identified by Optum Rx as a Generic drug based on available data resources, including, but not limited to, Medi-Span, which classifies drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "Generic" by the manufacturer, the pharmacy, or Your Physician may not be classified as Generic by Optum Rx.

Network Pharmacy means a retail or home delivery pharmacy that has:

- Entered into an agreement with Optum Rx to dispense Prescription Drugs to Covered Persons;
- Agreed to accept specified reimbursement rates for Prescription Drugs; and
- Been designated by Optum Rx as a Network Pharmacy.

New Prescription Drug Product means a Prescription Drug product or new dosage form of a previously approved Prescription Drug product, for the period of time starting on the date the Prescription Drug product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ending on the earlier of the following dates:

- The date it is assigned to a tier by Optum Rx's PDL Management Committee; or
- December 31st of the following calendar year.

Participation means the percentage of the cost You are required to pay for certain Prescription Drugs.

PDL means Prescription Drug List; see the definition of Prescription Drug List (PDL) below.

Pharmacy and Therapeutics (P&T) Committee means the committee that Optum Rx designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Prescription Drug means a medication, product, or device that has been approved by the Food and Drug Administration and that may, under federal or state law, be dispensed only using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs also include:

- Inhalers (with spacers);
- Insulin;
- The following diabetic supplies:
  - Insulin syringes with needles;
  - Blood-testing strips - glucose;
  - Urine-testing strips - glucose;
  - Ketone-testing strips and tablets;
  - Lancets and lancet devices; and
  - Glucose monitors.

Prescription Drug Charge means the rate Optum Rx has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) means a list that categorizes into tiers medications, products, or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to periodic review and modification (as frequently as monthly). You may determine to which tier a particular Prescription Drug has been assigned by visiting www.umr.com, and navigating to the Pharmacy section, or calling Optum Rx at 877-559-2955.

Therapeutic Class means a group or category of Prescription Drugs with similar uses and/or actions.

Therapeutically Equivalent means when Prescription Drugs have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge, also known as the retail price, means the amount charged to customers who have no health coverage for Prescription Drugs.

VISION CARE

The Plan will pay for Covered Expenses for vision care Incurred by a Covered Person, subject to any required Deductible, Co-pay if applicable, Plan Participation amount, maximums, and limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge, the maximum fee schedule, or the Negotiated Rate as applicable.

COVERED BENEFITS

- Vision therapy services (including orthoptics) or supplies.

EXCLUSIONS

Benefits will NOT be provided for any of the following:

- Sunglasses or subnormal vision aids.
- The fitting and/or dispensing of non-prescription glasses or vision devices, whether or not prescribed by a Physician or optometrist.
- Correction of visual acuity or refractive errors.
- Aniseikonia.
- Eye exam.
- Refraction.
- Lenses.
  - Single.
  - Bifocal.
  - Trifocal.
  - Lenticular.
  - Progressive.
- Frames.
- Elective Contacts.
- Contact lens fitting.
- Safety lenses and frames.
- Eye surgeries used to improve or correct eyesight for refractive disorders, including LASIK surgery, radial keratotomy, refractive keratoplasty, or similar surgery.

HEARING AID BENEFITS

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by UnitedHealthcare Hearing.

UnitedHealthcare Hearing provides a full range of hearing health benefits that deliver value, choice, and a positive experience.

UnitedHealthcare Hearing offers:

- Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
- Access to a network of credentialed hearing professionals at more than 5,000 locations nationwide.
- Convenient ordering with hearing aids available in person or through home delivery.

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-855-523-9355, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhchearing.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- Receive a hearing test by a UnitedHealthcare Hearing provider. During the appointment, You will decide if You would like to have Your hearing aids fitted in person with Your hearing provider or to have Your hearing aids delivered directly to Your home (for select hearing aid models only). A broad selection of name-brand and private-labeled hearing aids is available.
- If You choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered by the provider and sent directly to the provider's office. You will be fitted with the hearing aid(s) by the local provider. If You choose home delivery, the hearing aids will be sent directly to Your home within 5-10 business days from the order date.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-855-523-9355 or visit uhchearing.com.

MENTAL HEALTH BENEFITS

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, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedules of Benefits of this PD. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate as applicable.

COVERED BENEFITS

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

Residential Treatment, or **Residential** 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).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of 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 a program must be a less restrictive alternative to Inpatient treatment.

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 the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

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

COVERED BENEFITS

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

Residential Treatment or **Residential** 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).

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

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the 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.

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 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(as further described below).

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.

The benefit amounts payable under the Schedules of Benefits of this PD may be affected if the requirements described for Utilization Management are not satisfied. Generally speaking, Physicians, facilities**,** and other health care professionals who access a Managed Care UnitedHealthcare Network Provider for a service or procedure are responsible for obtaining 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.

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 PD. Refer to the Glossary of Terms section of this PD 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.

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 or access www.umr.com **before** receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over $1,500 or Durable Medical Equipment rentals over $500 per month.
- Prosthetics over $1,000.
- Qualifying Clinical Trials (as defined in the Covered Medical Benefits section of this PD).
- Chemotherapy (cancer diagnosis).
- Radiation therapy.
- Dialysis.
- Outpatient surgery not performed in Physician's office.
- 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.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.

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

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty of $250 may be applied to applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization.

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

The fact that a Covered Person requests 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.

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.

Complex Condition CARE Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Complex Condition CARE opportunities are identified by using a system-integrated, automated and manual trigger lists during the Prior Authorization review process. Other Complex Condition CARE 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 UMR Care Management's 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

CARE Cues

CARE Cues features a digital solution for clinical gaps in care, including care for behavioral health and substance use disorder. The CARE Cues program is integrated into a Covered Person's umr.com portal with notifications sent to the Covered Person's email that include next best action education and prompts to close the gap(s) in care.

There are over 150 digital gaps in care, including missed wellness / preventative opportunities, duplicative treatment, treatment disparities, condition management, immunizations, chronic condition drug interactions, and more. The email notifications will be offered to those Covered Persons with viable email addresses on file.

Complex Condition CARE (Case Management)

Complex Condition CARE services are designed to identify catastrophic and complex Illnesses, transplants, and trauma cases. Participants are identified using system-integrated, automated and manual trigger lists, including the Prior Authorization review process. Other Complex Condition CARE trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals. UMR CARE nurse managers work directly with the patient, the patient's family members, the treating Physician, and the facility to mobilize appropriate resources for the Covered Person's care. UMR Care Management's philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future.

Ongoing Condition CARE (Disease Management)

Ongoing Condition CARE identifies those individuals who have certain ongoing conditions and would benefit from this program. Specially trained CARE nurses work telephonically with Covered Persons to help them improve their conditions and maintain quality of life. Our unique approach to Ongoing Condition CARE identifies individuals with one or more of the seven targeted conditions as asthma (adult and pediatric), coronary artery disease (CAD), heart failure (HF), chronic obstructive pulmonary disease (COPD), diabetes (adult and pediatric), hypertension (high blood pressure), and depression). We use medical and pharmacy claims to identify Covered Persons who are eligible to participate in the program. If claims history is not available, Ongoing Condition CARE candidates may be initially identified using a Health Condition Survey. The survey is a general screening questionnaire available to all Covered Persons age 18 and over that asks a few questions about each of the conditions managed in the program. Program participants can also be identified through referrals from the Prior Authorization process, Covered Person self-referrals, other CARE programs, the employer, or the Covered Person's Physician.

Maternity CARE

Maternity CARE provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of long-term hospital stays for both mothers and babies. Program members are contacted via telephone by CARE nurses at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. This program also offers an educational call and materials specifically to assist the participant's support person. The CARE nurses also help members understand their Plan's benefit information.

UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, face risks not only to their babies, but also to themselves while they are pregnant. Members self-enroll in the pre-pregnancy coaching program by calling UMR Care Management's toll-free number. They are then contacted by CARE nurses who have extensive clinical backgrounds in obstetrics/gynecology. The CARE nurses complete pre-pregnancy assessments to determine risk levels, if any, and provide members with education based on their needs. The CARE nurses also help members understand the Plan's benefit information.

Plans may choose to utilize UMR's standard incentive, which is a prepaid reward card to each member who enrolls in the first or second trimester and actively participates in the Maternity CARE program.

COORDINATION OF BENEFITS

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

(Applies to Benefit Plan(s) 009, 010) The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Copays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

(Applies to Benefit Plan(s) 008) The order of benefit determination rules determine which plan will pay first (which is the 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 the 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 motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

- 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 will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.

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

- The plan that covers a person as a Dependent is generally secondary. The plan that covers a person as a Dependent is primary only when both plans agree that the plan providing Continuation of Coverage should always pay secondary when the person who elected Continuation of Coverage is covered by another plan as a Dependent. See continuation coverage below. Also see the section on Medicare, below, for exceptions.

- If an individual is covered under a Spouse's plan and also under 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 has covered either of the parents the longest is primary.

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

  - If the parents are not married and reside separately, or are divorced or legally separated, (whether or not they have ever been married), the order of benefits is:

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

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

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

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or retiree the longest 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 may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

MEDICARE

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

(Applies to Benefit Plan(s) 009, 010) The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Copays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

(Applies to Benefit Plan(s) 008) The order of benefit determination rules determine which plan will pay first (which is the 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 the 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 Medicare Part A but has chosen not to elect Medicare Part B, this Plan will reduce its payments on Medicare Part B services as though Medicare Part B was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

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

- This Plan generally pays first under the following circumstances:

    - You continue to be a Person Eligible to Participate and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.

- You continue to be a Person Eligible to Participate, Your covered spouse becomes eligible for and enrolls in Medicare, and Your Spouse is also covered under a retiree plan through his or her former employer. In this case, this Plan pays first for You and Your covered Spouse, Medicare pays second, and the retiree plan pays last.

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

- Medicare generally pays first under the following circumstances:

  - You are no longer a Person Eligible to Participate; and

  - You or Your Spouse has Medicare coverage due to age, plus You or Your Spouse also has Continuation of Coverage through the Plan; or

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

  - You or Your covered Spouse has retiree coverage plus Medicare coverage; or

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

- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as primary payer.

TRICARE

If a Person Eligible to Participate is on active military duty, TRICARE is the only coverage available to that individual. TRICARE benefits are not coordinated with this Plan.

In all instances where a Person Eligible to Participate in the Plan is also a TRICARE beneficiary, TRICARE will pay secondary to this Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if 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 the Plan 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 from 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, Your guardians, Your beneficiaries, and other representatives who may receive funds subject to the Plan's Subrogation, Reimbursement, and / or Offset rights or who may initiate or have recovery rights against a third party, unless otherwise stated.

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

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

The following persons and entities are considered third parties:

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

By Your participation in the Plan, 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.
- Including the Plan's name as co-payee on any and all settlement drafts.
- Complying with the terms of this section.

- Acceptance of any benefits under the Plan is constructive notice of the Plan's Subrogation , Reimbursement, and / or Offset right;

- The Plan shall have an equitable lien on any funds received by You or Your attorney from any source and such funds shall be held in trust until such time as the Plan's Subrogation, Reimbursement, and / or Offset rights are satisfied.

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 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 by the Participant, a court or any other entity, 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 by the Participant, a court or any other entity. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights. The Plan's rights will not be reduced or affected as a result of any fault or claim on the part of the Participant, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar legal theory. Accordingly, any lien reduction statutes, which reduce a subrogating Plan's recovery, will not be applicable to the Plan and will not reduce the Plan's 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 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; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

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

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

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

- No allocation of damages, settlement funds, or any other recovery by You 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.

In addition to the Plan's rights of Subrogation, Reimbursement, and Offset, the Plan has a property right to an equitable interest in any and all third party payments made to or on behalf of a Participant on account of an Injury or Illness. The Plan's rights include an equitable lien on any such third party payments. These rights to and interests in third party payments exists without regard to whether the Plan exercises its Subrogation, Reimbursement, and / or Offset rights. The Plan's equitable interest in such third party payments means that third party payments made to or on behalf of a Participant belong to the Plan, to the extent of benefits paid or expected to be paid in relation to the associated Illness or Injury. Any third party payments subject to such equitable interest exist separately from the property and estate of the Participant, such that the death of the Participant or filing of bankruptcy of the Participant will not affect the Plan's equitable interest, the funds subject to such interest or the Plan's Subrogation, Reimbursement, and / or Offset rights.

A Participant (or his representative) must: (i) hold in constructive trust for the Plan any third party payment received in relation to an Illness or Injury and belonging to the Plan pursuant to the terms of the Plan; (ii) return to the Plan from that third party payment the amount of any and all benefits that the Plan has paid in relation to the Illness or Injury, as well as any costs and fees associated with the enforcement of the Plan's rights, as soon as the third party payment is made, regardless of the source and regardless of fault. This includes payments and recoveries granted by whole, partial or undifferentiated judgements. he source and regardless of fault. This includes payments and recoveries granted by whole, partial or undifferentiated judgements.
e source and regardless of fault. This includes payments and recoveries granted by whole, partial or undifferentiated judgements.

If there is more than one party potentially responsible for charges paid by the Plan, the Plan is not required to select a particular party from whom a refund is due. If an unallocated settlement fund is meant to compensate multiple injured parties of which the Participant is only one, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek a refund.

The Plan has the right to offset benefits otherwise payable under the Plan against any amount belonging to the Plan as a result of the Plan's rights to third party payments. The Plan's right of offset means that if the Participant or his / her representative does not return any amounts belonging to the Plan as a result of the Plan's right to third party payments, the Plan may recover part or all of the amount owed by offsetting that amount against benefits otherwise payable. The Plan's right of offset exists with respect to benefits it has not paid (for previously incurred expenses) and to any future benefits otherwise payable under the Plan.

GENERAL EXCLUSIONS

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

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below 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. **Abdominoplasty**.

2. **Abortions.**

3. **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.

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

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

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

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

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

9. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.

10. **Biofeedback Services.**

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

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

13. **Breast Pumps,** unless covered elsewhere in this PD.

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

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

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

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

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

18. **Contraceptive Products and Counseling,** unless covered elsewhere in this PD.

19. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

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

21. **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 for which the individual is charged.

22. **Custodial Care** as defined in the Glossary of Terms of this PD.

23. **Dental Services,** unless covered elsewhere in this PD.

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

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

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

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

28. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule, as applicable. This exclusion does not apply to payment that may be required under the No Surprises Act.

29. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment.

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

31. **Financial Counseling.**

32. **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 bodybuilding.

33. **Foot Care (Podiatry):** Routine foot care, unless covered elsewhere in this PD.

34. **Gender Transition:** Treatment, drugs, medicines, services, and supplies for, or leading to and including, gender transition surgery.

35. **Genetic Counseling** other than based on Medical Necessity, unless covered elsewhere in this PD.

36. **Genetic Testing,** unless covered elsewhere in this PD.

37. **Growth Hormones / Growth Hormone Therapy,** except for growth hormone treatment prescribed for a Participant or their Dependent up to age 19 when Medically Necessary**.**

38. **Hearing Services:**

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

39. **Home Modifications:** Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.

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

41. **Infertility Treatment:**

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

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

42. **Intraocular Lenses Other Than Conventional Intraocular Cataract Lenses.**

43. **Lamaze Classes** or other childbirth classes.

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

45. **Liposuction,** regardless of purpose.

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

47. **Mammoplasty or Breast Augmentation,** unless covered elsewhere in this PD.

48. **Marriage Counseling.**

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

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

51. **Nocturnal Enuresis Alarm.**

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

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

54. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

55. **Nursery and Newborn Expenses** for a child that does not qualify as the Dependent of a Participant.

56. **Nutrition Counseling,** unless covered elsewhere in this PD.

57. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** unless covered elsewhere in this PD.

58. **Over-the-Counter Medication, Products, Supplies, or Devices,** unless covered elsewhere in this PD.

59. **Palliative Foot Care.**

60. **Panniculectomy,** unless determined by the Plan to be Medically Necessary.

61. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones and guest trays.

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

63. **Preventive / Routine Care Services,** unless covered elsewhere in this PD.

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

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

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

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

68. **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.

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

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

71. **Services Provided By a Close Relative.** See the Glossary of Terms section of this PD for a definition of Close Relative.

72. **Sex Therapy.**

73. **Sexual Function:** Diagnostic service, non-surgical and surgical procedures and Prescription Drugs (unless covered under the Prescription Drug Benefits section of this PD) in connection with treatment for male or female impotence.

74. **Standby Surgeon Charges.**

75. **Sterilizations.**

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

77. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.

78. **Taxes:** Sales taxes and shipping and handling charges, unless covered elsewhere in this PD.

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

80. **Tobacco Addiction:** Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine, unless covered elsewhere in this PD.

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

82. **Travel:** Travel costs, unless covered elsewhere in this PD.

83. **Vision Care,** unless covered elsewhere in this PD. (Refer to the Vision Care Benefits section of this PD).

84. **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.

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

86. **Weekend Admissions** to Hospital confinement (admissions taking place after 3:00 pm on Fridays or before noon on Sundays) unless the admission is deemed an Emergency or is for care related to pregnancy that is expected to result in childbirth.

87. **Weight Control:** Treatment, services, or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness. This exclusion does not apply to specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this PD.

88. **Wigs (Cranial Prostheses), Toupees, Hairpieces, Hair Implants or Transplants, or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss, unless covered elsewhere in this PD.

89. **Workers' Compensation:** Health care services for which other coverage is required by federal, state, or local law to be bought or provided through other arrangements. This includes coverage required by workers' compensation or similar legislation. This exclusion does not apply to employers that are not required by law to buy or provide, through other arrangements, workers' compensation insurance for employees, owners, and/or partners.

90. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

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

CLAIMS AND APPEAL PROCEDURES

This Section explains the Plan's administrative procedures for the processing of Claims, the Plan's Appeal procedures in the event a Claim is denied and the procedures for external review. Both the Claim and Appeal procedures are intended to provide a full and fair review.

If Your claim is denied, the Plan provides for two levels of Appeal. The first level Appeal is decided by the Claims Administrator and the second level Appeal is decided by the Plan Administrator. If You file a first and second level Appeal and they are both denied, then You may request an external review of the Claim under certain circumstances as more fully described below.

FILING A CLAIM

How to File a Claim

You will receive a Participant identification card which will contain important information, including Claim filing directions and contact information. The Participant identification card will show Your Participating Provider Network and the Medical Management Administrator.

At the time You receive treatment, show the Participant identification card to Your provider of service. In most cases, Your provider will file Your Claim for You. You may file the Claim Yourself by submitting the required information to the Claims Administrator at the following address:

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

Most Claims under the Plan will be "post service claims. A "post service claim" is a Claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

- the date of service;
- the name, address, telephone number and tax identification number of the provider of the services or supplies;
- the place where the services were rendered;
- the diagnosis and procedure codes;
- the amount of charges (including Network repricing information);
- the name of the Plan;
- the name of the Covered Person; and
- the name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Charge before the treatment is rendered, is not a "Claim" since an actual written Claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a Claim.

When to File a Claim

All Claims must be filed with the Claims Administrator within 12 months following the date services were Incurred. Claims filed after this time period will be denied.

Procedures for all Claims

The Plan's Claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

Time Period for Deciding Claims

To receive benefits under the Plan, the Claimant must follow the procedures outlined in this section. There are 4 different types of Claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of Claim are more fully described below:

- **Urgent Care Claims.** If Your Claim is considered an urgent care claim, the Claims Administrator will notify You of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Claims Administrator receives the Claim, unless You fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan. If You fail to provide sufficient information for the Plan to decide Your Claim, the Claims Administrator will notify You as soon as possible, but not later than 24 hours after the Claims Administrator receives the Claim, of the specific information necessary to complete the Claim. The notification may be oral unless written notification is requested by You. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify You of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Claims Administrator's receipt of the specified additional information or (2) the end of the period afforded the Claimant to provide the specified additional information.

  A Claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize Your life or health or Your ability to regain maximum function or, in the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that could not be adequately managed without the care or treatment which is the subject of the Claim. In determining if the initial Claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending Physician that the Claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

- **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an Adverse Determination. In such a case, the Claims Administrator will notify You of the Adverse Determination at a time sufficiently in advance of the reduction or termination to allow You, the Claimant, to Appeal and obtain a determination on review of that Adverse Determination before reduction or termination of the benefit.

  Any request by You to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Claims Administrator will notify You of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the Claim provided that any such Claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- **Pre-Service Claims.** For a pre-service claim, the Claims Administrator will notify You of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the Claim. If, due to matters beyond the control of the Plan, the Claims Administrator needs additional time to process a Claim, the Claims Administrator may extend the time to notify You of the Plan's benefit determination for up to 15 days provided that the Claims Administrator notifies You within 15 days after the Plan receives the Claim of the circumstances requiring the extension and of when the Claims Administrator expects to make its decision. However, if such an extension is necessary due to Your failure to submit the information necessary to decide the Claim, the notice of extension must specifically describe the required information and You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

  A Claim for benefits is considered a pre-service claim if the Claim requires approval, in part or in whole, in advance of obtaining the health care in question.

- **Post-Service Claims.** For a post-service claim, the Claims Administrator will notify You of the Plan's Adverse Determination within a reasonable period of time, but not later than 30 days after receipt of the Claim. If, due to matters beyond the control of the Plan, the Claims Administrator needs additional time to process a Claim, the Claims Administrator may extend the time for notifying You of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Claims Administrator notifies You within 30 days after the Plan receives the Claim, of the circumstances requiring the extension and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to Your failure to submit the information necessary to decide the Claim, the notice of extension will specifically describe the required information and You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

  A Claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that You have already received (or any other Claim for health benefits that is not a pre-service claim or an urgent care claim).

Notice of Initial Adverse Determination

If the Claims Administrator denies a Claim, it must provide to You in writing or by electronic communication:

- Information sufficient to identify the Claim involved, including the date of service, the health care provider, the Claim amount (if applicable) and a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning);

- The specific reasons for the decision, including the disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the Claim;

- The relevant Plan provision upon which the decision is based;

- A description of any additional information or material that You must provide in order to perfect the Claim and an explanation of why such information or material is necessary;

- A description of the Plan’s internal appeal and external review procedures (including information on how to file an internal appeal and external review), the time limits applicable to such procedures, and a statement of the Claimant’s right to bring a lawsuit following an Adverse Determination on review;

- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Determination, either a copy of any such rule, guideline, protocol or other similar criterion or a statement that the same will be provided upon Your request and without charge;

- If the Adverse Determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to Your medical circumstances or (b) a statement that the same will be provided upon Your request and without charge;

- In the case of an Adverse Determination involving urgent care, a description of the expedited review process applicable to such claim; and

- Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to PPACA to assist individuals with internal Claims and Appeals and external review processes.

  For an Adverse Determination concerning an urgent care claim, the information described in this section may be provided to You orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to You no later than three days after the oral notification.

APPEAL OF CLAIM DENIAL

You may file an Appeal after receiving an Adverse Determination of the Claim. The Plan has two levels of internal Appeal. All first level appeals must be made to the Claims Administrator and all second level appeals must be made to the Plan Administrator, as further explained below.

First Level Appeal: This is a **mandatory** appeal level.

If You submit a Claim for Plan benefits and it is initially denied under the procedures described above, You may request a review of that denial under the procedures described below. You have 180 days after You receive notice of an initial Adverse Determination within which to request a review of the Adverse Determination. All requests for review of initially denied Claims (including all relevant information) must be submitted to the Claims Administrator at the following address:

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

Second Level Appeal: This is a **mandatory** appeal level.

If You submit a first level Appeal and it is denied under the procedures described above, You may request a review of that denial under the procedures described below. You have 60 days after You receive notice of an Adverse Determination at the first level of Appeal to request a second level Appeal of the Adverse Determination. A request for review of the denial of a first level Appeal must be submitted to the Plan Administrator at the following address:

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

Review Procedures Applicable to Appeals:

The following review procedures apply to Appeals filed within the applicable time periods:

- The Plan will provide a review that does not afford deference to the Adverse Determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the Adverse Determination that is the subject of the Appeal and who is not a subordinate of the individual who made that Adverse Determination.

- The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any Adverse Determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the Appeal, nor a subordinate of any such individual.

- The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an Adverse Determination, without regard to whether the advice is relied upon in making the Adverse Determination on review.

- For a requested review of an Adverse Determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and You by telephone, facsimile or other available similarly expeditious method.

- The reviewer will afford You an opportunity to review and receive, without charge, all relevant documents, information and records relating to the Claim and to submit issues and comments relating to the Claim in writing to the Claims Administrator. The reviewer will take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim regardless of whether the information was submitted or considered in the initial benefit determination.

- You will be provided, free of charge, any new or additional evidence considered, relied upon or generated by the Plan in connection with the Claim. Such evidence will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its final Adverse Determination on review to give You a reasonable opportunity to respond prior to such determination.

- Before the Plan can issue a final internal Adverse Determination based on a new or additional rationale, You must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is required to be provided to give You a reasonable opportunity to respond prior to that date. Effective January 1, 2018, if the new or additional evidence is received so late that it would be impossible to provide it to the Claimant in time for the Claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal Adverse Determination is tolled until such time as the Claimant has a reasonable opportunity to respond. After the Claimant responds, or has a reasonable opportunity to respond but fails to do so, the Claims Administrator shall notify the Claimant of the Plan's benefit determination as soon as a plan acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

- The Plan will ensure that all Claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

- The Plan will provide You with continued coverage pending the outcome of an internal Appeal.

Time Period for Deciding Appeals:

The time period for deciding Appeals depend on the type of Claim, as further explained below.

- **Urgent Care Claims.** The Plan provides for two levels of Appeal for urgent care claims. For each level of Appeal, the reviewer will notify You of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives Your request for review of the initial Adverse Determination or of the first-level Appeal Adverse Determination.

- **Pre-Service Claims.** Within a reasonable period of time appropriate to the medical circumstances, but no later than 15 calendar days after the Plan receives the request for review for the first appeal, and another 15 calendar days for the second appeal, or a maximum of 30 calendar days for the two appeal levels.

- **Post-Service Claims.** The Plan provides for two levels of Appeals for a post-service claim. At each level of Appeal, the reviewer will notify You of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives Your request for review of the initial Adverse Determination (or of the first level Appeal Adverse Determination).

Notice of Adverse Determination for Both Levels of Appeal:

Upon completion of its review of an initial Adverse Determination or a first-level Appeal Adverse Determination, the reviewer will give You, in writing or by electronic notification, a notice of its benefit determination. For an Adverse Determination, the notice will include:

- Information sufficient to identify the Claim involved, including the date of service, the health care provider, the Claim amount (if applicable) and a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning);

- The specific reasons for the decision, including the denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the Claim; in the case of a notice of final internal Adverse Determination, this description must also include a discussion of the decision;

- The relevant Plan provisions on which the decision is based;

- A statement that You are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to Your Claim for benefits;

- A description of the Plan's second level Appeal procedures (if applicable) and external review procedures (including information on how to file a second level Appeal (if applicable) and external review) and a statement of the Claimant's right to bring a lawsuit following an Adverse Determination on review;

- If an internal rule, guideline, protocol or other criterion was relied upon in making the Adverse Determination on review, either a copy of any such rule, guideline, protocol or other similar criterion or a statement that the same will be provided without charge to You upon request;

- If the Adverse Determination on review is based on a Medical Necessity, Experimental Treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the Claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request; and

- Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to PPACA to assist individuals with internal Claims and Appeals and external review processes.

CALCULATION OF TIME PERIODS FOR CLAIMS AND APPEALS

For purposes of the time periods described in the Plan's Claim procedures, the periods of time during which a benefit determination is required to be made begins at the time a Claim (or a request for review of a denied Claim) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to Your failure to submit all information necessary for a Claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to You until the date You respond or, if earlier until 45 days from the date Your receive (or were reasonably expected to receive) the notice requesting additional information.

ADVERSE DETERMINATION

For purposes of the Plan's Claim procedures, an "Adverse Determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

PLAN'S FAILURE TO FOLLOW PROCEDURES

If the Plan fails to follow the Claim and Appeal procedures described above, You will be deemed to have exhausted the Plan internal Claim and Appeal procedures and You will be entitled to pursue any available remedy (including any available external review process) under State or Federal law on the basis that the Plan has failed to provide a reasonable Claims procedure that would yield a decision on the merits of the Claim. However, the Plan will not be treated as failing to follow its Claim procedures and You will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to You as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and You. You may request a written explanation of any violation by the Plan of these procedures. If You request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal Claim and Appeal procedures to be exhausted. If a court or external review rejects Your request for an immediate review (based on a claim that You should be deemed to have exhausted the Plan's internal Claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to You a notice of Your right to resubmit Your internal Appeal within a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for You to re-file Your Claim will begin to run when You receive that notice from the Plan.

EXTERNAL REVIEW OF DENIED CLAIMS

Standard External Review

If You have exhausted the Plan's internal Appeal process (or if You are eligible to request an external review for any other reason under the above procedures), You may request an external review of the Plan's final Adverse Determination for certain health benefit Claims.

The external review process (including the expedited external review process described later in these procedures) is not available for review of all internal Adverse Determinations. Specifically, external review is not available for review of an internal Adverse Determination that is based on a determination that a Claimant fails to meet the eligibility requirements under the terms of the Plan. The external review process is available only for:

- 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 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.

For purposes of determining whether a Claim is eligible for external review, the term "medical judgment" includes, but is not limited to, determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or its determination that a treatment is an Experimental or Investigational Treatment. Effective January 1, 2018, the term "medical judgment" shall also include the Plan's determination whether a Participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program or its determination whether a plan is complying with the nonquantitative treatment limitation provisions of Code section 9812 and Treasury Regulation § 54.9812, which generally require, among other things, parity in the application of medical management techniques.

For any Adverse Determination for which external review is available, the following external review requirements apply:

You have 4 months following the date You receive notice of the Plan's final internal Adverse Determination within which to request an external review. If there is not a corresponding date that is four months after receipt of such notice, the external review request must be filed by the first day of the fifth month following receipt of the notice. In addition, if the last filing date falls on a Saturday, Sunday, or Federal holiday, the filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The request for an external review must be submitted to the following address:

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

Within 5 business days following the date the Plan receives Your external review request the Claims Administrator will complete a preliminary review to determine whether:

- the Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

- The Adverse Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

- The Claimant has exhausted the Plan's internal Appeals process unless the Claimant is not required to exhaust the internal Appeals process under the interim final regulations; and

- The Claimant has provided all the information and forms required to process an external review.

The Claims Administrator will notify You in writing within one business day after it completes the preliminary review whether the Claim is eligible for the external review process:

- If the request is complete, but the Claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the Employee Benefits Security Administration.

- If the request is not complete, the notice will describe information or materials needed to make the request complete. In addition, You will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

Following the Claims Administrator's preliminary review, if the request is eligible for external review, the Claims Administrator will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Claims Administrator will forward to the IRO all information and materials relevant to the final internal Adverse Determination.

The assigned IRO will notify You in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding Your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Claims Administrator. The Claims Administrator, based upon any new information received, may reconsider its final internal Adverse Determination. Reconsideration by the Claims Administrator will not delay the external review process. If the Claims Administrator decides to reverse the denial, You will be notified of the decision within one business day and the external review process will end. If the Claims Administrator does not reconsider its final internal Adverse Determination, the IRO will continue to proceed with the external review process.

If the Claims Administrator does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- The Claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan, Claimant, or the Claimant's treating Physician;
- The terms of the Plan;

- Appropriate practice guidelines, which must include applicable evidence-based standards;
- Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer.

Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to You and the Plan. The IRO's notice is required to contain the following:

- A general description of the reason for the request for external review, including information sufficient to identify the Claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to You;
- A statement that judicial review may be available to You; and
- Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review:

You may request an expedited external review if You have received:

- An Adverse Determination if the Adverse Determination involves a medical condition for which the time frame for completion of an expedited internal Appeal under the Plan's internal Claim procedures would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function and You have filed a request for an expedited internal Appeal; or

- A final internal Adverse Determination, if You have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function or if the final internal Adverse Determination concerns an admission, availability of care, continued stay or health care item or service for which You received emergency services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

- If You file a request for an expedited external review, upon receipt of Your request the Claims Administrator will immediately determine whether Your request meets the reviewability requirements for a standard external review, and immediately send the notice required for a standard external review (see the "Standard External Review" section above).

- Following the Claims Administrator's preliminary review, if the request is eligible for external review, the Claims Administrator will assign an independent review organization (IRO) to make a determination on the request for external review. The Claims Administrator will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal Adverse Determination.

- To the extent they are available, the IRO will consider the same documents and information applicable to the standard external review process (see the "Standard External Review" section above) and provide notice of the decision to the Claimant and the Claims Administrator (either in writing or orally) as expeditiously as the Claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Claims Administrator. If notice is not provided in writing, the IRO must provide written notice to the Claimant and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice must include the same information required for the standard external review process (see the "Standard External Review" section above).

Effect of External Review Determination

A determination on external review is binding on the Plan and the Claimant, except to the extent that other remedies are available under applicable State or Federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a Claim at any time, including after a decision that denies the Claim. When an external review decision requires the Plan to provide benefits or payment on a Claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.
decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

STATUTE OF LIMITATIONS FOR LEGAL ACTION

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/Appeal decision by the Claims Administrator has been rendered (or deemed rendered).

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit Claim or Appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a Claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Claims Administrator, in writing, to the contrary.

PHYSICAL EXAMINATIONS

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a Claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator or Claims Administrator may reasonably require during the pendency of a Claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this PD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., Continuation of Coverage notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on Continuation of Coverage. (Please note that the examples listed are not all-inclusive.)

Any action that constitutes fraud will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law. In addition, as permitted by the ACA, the Plan reserves the right to retroactively rescind coverage due to fraud or an intentional misrepresentation of material fact.

Each Covered Person must:

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

In order to maintain the integrity of this Plan, each Covered Person is 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 at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If a Participant is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her Participating Entity will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are timely paid; and
- The Participant has a written, approved leave from the applicable Participating Entity.

Coverage will be continued for up to the greater of:

- The leave period required by the federal FMLA and any amendment; or
- The leave period required by applicable state law.

A Participant may choose not to retain group health coverage during an FMLA leave. When the Participant returns to work following the FMLA leave, the Participant's coverage will usually be restored to the level the Participant would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

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

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures 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 Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

PROTECTED HEALTH INFORMATION

Use and Limited Disclosure of Protected Health Information

In the course of its administration, the Plan creates, receives, uses, maintains and discloses health information about the Plan's Participants and their Dependents in the course of providing health benefits.

> For ease of reference, in the remainder of this section, the words "you," "your," and "yours" refers to any individual with respect to whom the Plan receives, creates or maintains Protected Health Information, including Participants and their respective Dependents.

The Plan is required by law to take reasonable steps to protect your Protected Health Information from inappropriate use or disclosure.

> Your "Protected Health Information" (PHI) is information about your past, present, or future physical or mental health condition, the provision of health care to you, or the past, present, or future payment for health care provided to you, but only if the information identifies you or there is a reasonable basis to believe that the information could be used to identify you. Protected Health Information includes information of a person living or deceased (for a period of fifty years after the death.)

The Plan is required by law to provide notice to you of its duties and privacy practices with respect to your PHI, and is doing so through this section. This section describes the different ways in which the Plan uses and discloses PHI as part of its plan administration. It is not feasible to describe in detail all of the specific uses and disclosures the Plan may make of PHI, so this section describes all of the categories of uses and disclosures of PHI that the Plan may make and, for most of those categories, gives examples of those uses and disclosures.

The Plan is required to abide by these terms until they are replaced. The Plan may change its privacy practices at any time and, if any such change requires a change to these terms, the Plan will revise and re-distribute this section according to the Plan's distribution process. Accordingly, the Plan can change these terms at any time. The Plan has the right to make any such change effective for all of your PHI that the Plan creates, receives or maintains, even if the Plan received or created that PHI before the effective date of the change.

Please note that these terms apply only to your PHI that the Plan maintains through its administration. It does not affect your Physician's or other health care provider's privacy practices with respect to your PHI that they maintain.

Receipt of Your PHI by the Plan Administrator and its Business Associates

<u>The Plan, in administering coverage, may disclose your PHI to, and allow use and disclosure of your PHI by, the Plan Administrator and the Plan's Business Associates without obtaining your authorization</u>.

- **Plan and the Plan Administrator:** The Trust, through the Archdiocese, is sponsor of the Plan on behalf of the Participating Entities, and the Archdiocese of Denver Management Corporation is the administrator of the Plan, (the "Plan Administrator"). The Plan may disclose to the Plan Administrator, in summary form, claims history and other information so that the Plan Administrator may solicit premium bids for health benefits, or modify, amend or terminate the Plan. This summary information omits your name and Social Security Number and certain other identifying information. The Plan may also disclose information about your participation and enrollment status in the Plan to the Plan Administrator and receive similar information from the Plan Administrator. If the Plan Administrator agrees in writing that it will protect the information against inappropriate use or disclosure, the Plan also may disclose to the Plan Administrator a limited data set that includes your PHI, but omits certain direct identifiers, as described later in this Section.

The Plan may disclose your PHI to the Plan Administrator for plan administration functions performed by the Plan Administrator on behalf of the Plan, if the Plan Administrator certifies to the Plan that it will protect your PHI against inappropriate use and disclosure.

Example: The Plan Administrator reviews certain appeals of claim denials under the Plan. The Plan provides PHI regarding an appealed claim to the Plan Administrator for that review, and the Plan Administrator uses PHI to make the decision on appeal.

- **Business Associates:** The Trust and the Plan Administrator hire third parties, such as a third party administrator (the "Claims Administrator"), to help the Trust provide health benefits through the Plan. These third parties are known as "Business Associates." The Plan may disclose your PHI to Business Associates, like the Claims Administrator, who are hired by the Trust or the Plan Administrator to assist or carry out the terms of the Plan. In addition, these Business Associates may receive PHI from third parties or create PHI about you in the course of carrying out the terms of the Plan. On behalf of the Plan, the Trust and the Plan Administrator must require all Business Associates to agree in writing that they will protect your PHI against inappropriate use or disclosure, and will require their subcontractors and agents to do so, too.

For purposes of this section, all actions of the Business Associates that are taken on behalf of the Plan are considered actions of the Plan. For example, health information maintained in the files of the Claims Administrator is considered maintained by the Plan. When this section refers to the Plan taking various actions with respect to health information, those actions may be taken by the Trust, the Plan Administrator or a Business Associate on behalf of the Plan.

Duties of the Plan Administrator

The Plan Administrator agrees that it will:

- Not use or further disclose PHI other than as permitted or required by the Plan Document or as required by law;

- Not sue or disclose PHI for employment-related actions and decisions or in connection with any other benefit Plan of the Plan Administrator unless authorized by the individual;

- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for which the Plan Administrator becomes aware;

- make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services for the purpose of determining the Plan's compliance with HIPAA;

- If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, it will limit further use and disclosure to those purposes that make the return or destruction infeasible;

- Ensure that adequate separation between the Plan and Plan Administrator is established and supported by reasonable and appropriate security measures and ensure only the following employees or classes of employees will be given access to PHI:

    - Privacy Officer
    - Human Resources Representative

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of all electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan (except with respect to enrollment and disenrollment information and summary health information and PHI disclosed pursuant to an authorization under 45 CFR section 164.508) and ensure that any agents to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect such information; and

- Report to the Plan any security incident of which it becomes aware.

How the Plan May Use or Disclose Your PHI

The Plan may use and disclose your PHI for the following purposes without obtaining your authorization. And, with only limited exceptions, the Plan will send all mail to you, the Participant. This includes mail relating to your Spouse and other family members who are covered under the Plan. If a person covered under the Plan has requested Restrictions or Confidential Communications, and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Your Health Care Treatment: The Plan may disclose your PHI for treatment (as defined in applicable federal rules) activities of a health care provider.

- **Example:** If your doctor requested information from the Plan about previous claims under the Plan to assist in treating you, the Plan could disclose your PHI for that purpose.

- **Example:** The Plan might disclose information about your prior prescriptions to a pharmacist for the pharmacist's reference in determining whether a new prescription may be harmful to you.

Making or Obtaining Payment for Health Care or Coverage: The Plan may use or disclose your PHI for payment (as defined in applicable federal rules) activities, including making payment to or collecting payment from third parties, such as health care providers and other health plans.

- **Example:** The Plan will receive bills from physicians for medical care provided to you that will contain your PHI. The Plan will use this PHI, and create PHI about you, in the course of determining whether to pay, and paying, benefits with respect to such a bill.

- **Example:** The Plan may consider and discuss your medical history with a health care provider to determine whether a particular treatment for which Plan benefits are or will be claimed is medically necessary as defined in the Plan.

The Plan's use or disclosure of your PHI for payment purposes may include uses and disclosures for the following purposes, among others:

- Obtaining payments required for coverage under the Plan;
- Determining or fulfilling its responsibility to provide coverage and/or benefits under the Plan, including eligibility determinations and claims adjudication;
- Obtaining or providing reimbursement for the provision of health care (including coordination of benefits, subrogation, and determination of cost sharing amounts);
- Claims management, collection activities, obtaining payment under a stop-loss insurance policy, and related health care data processing;
- Reviewing health care services to determine medical necessity, coverage under the Plan, appropriateness of care, or justification of charges;
- Utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services;

The Plan also may disclose your PHI for purposes of assisting other health plans, health care providers, and health care clearinghouses with their payment activities, including activities like those listed above with respect to the Plan.

Health Care Operations: The Plan may use and disclose your PHI for health care operations (as defined in applicable federal rules) which includes a variety of facilitating activities.

- **Example:** If claims you submit to the Plan indicate that you have diabetes or another chronic condition, the Plan may use and disclose your PHI to refer you to a disease management program.

- **Example:** If claims you submit to the Plan indicate that the stop-loss coverage that the Plan has purchased may be triggered, the Plan may use or disclose your PHI to inform the stop-loss carrier of the potential claim and to make any claim that ultimately applies.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following purposes:

- Quality assessment and improvement activities;
- Disease management, case management and care coordination;
- Activities designed to improve health or reduce health care costs;
- Contacting health care providers and patients with information about treatment alternatives;
- Accreditation, certification, licensing or credentialing activities;
- Fraud and abuse detection and compliance programs.

The Plan also may use or disclose your PHI for purposes of assisting other health plans, health care providers and health care clearinghouses with their health care operations activities that are like those listed above, but only to the extent that both the Plan and the recipient of the disclosed information have a relationship with you and the PHI pertains to that relationship.

The Plan's use and disclosure of your PHI for health care operations purposes may include uses and disclosures for the following additional purposes, among others:

- Underwriting (with the exception of PHI that is genetic information) premium rating and performing related functions to create, renew or replace insurance related to the Plan;
- Planning and development, such as cost-management analyses;
- Conducting or arranging for medical review, legal services, and auditing functions;
- Business management and general administrative activities, including implementation of, and compliance with, applicable laws, and creating de-identified health information or a limited data set;

The Plan also may use or disclose your PHI for purposes of assisting other health plans, and any insurers and/or HMOs with respect to those plans, with their health care operations activities similar to both categories listed above.

- **Limited Data Set:** The Plan may disclose a limited data set to a recipient who agrees in writing that the recipient will protect the limited data set against inappropriate use or disclosure. A limited data set is health information about you and/or others that omits your name and Social Security Number/ITIN/equivalent and certain other identifying information.

- **Legally Required:** The Plan will use or disclose your PHI to the extent it is required to do so by applicable law. This may include disclosing your PHI in compliance with a court order, or a subpoena or summons. In addition, the Plan must allow the U.S. Department of Health and Human Services to audit Plan records.

- **Health or Safety:** When consistent with applicable law and standards of ethical conduct, the Plan may disclose your PHI if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or the health and safety of others.

- **Law Enforcement:** The Plan may disclose your PHI to a law enforcement official if the Plan believes in good faith that your PHI constitutes evidence of criminal conduct that occurred on the premises of a Participating Entity. The Plan also may disclose your PHI for limited law enforcement purposes.

- **Lawsuits and Disputes:** In addition to disclosures required by law in response to court orders, the Plan may disclose your PHI in response to a subpoena, discovery request or other lawful process, but only if certain efforts have been made to notify you of the subpoena, discovery request or other lawful process or to obtain an order protecting the information to be disclosed.

- **Workers' Compensation:** The Plan may use and disclose your PHI when authorized by and to the extent necessary to comply with laws related to workers' compensation or other similar programs.

- **Emergency Situation:** The Plan may disclose your PHI to a family member, friend, or other person, for the purpose of helping you with your health care or payment for your health care, if you are in an emergency medical situation and you cannot give your agreement to the Plan to do this.

- **Personal Representatives:** The Plan will disclose your PHI to your personal representatives appointed by you or designated by applicable law (a parent acting for a minor child, or a guardian appointed for an incapacitated adult, for example) to the same extent that the Plan would disclose that information to you. The Plan may choose not to disclose information to a personal representative if it has reasonable belief that: (1) you have been or may be a victim of domestic abuse by your personal representative; or (2) recognizing such person as your personal representative may result in harm to you; or (3) it is not in your best interest to treat such person as your personal representative.

- **Public Health:** To the extent that other applicable law does not prohibit such disclosures, the Plan may disclose your PHI for purposes of certain public health activities, including, for example, reporting information related to an FDA-regulated product's quality, safety or effectiveness to a person subject to FDA jurisdiction.

- **Health Oversight Activities:** The Plan may disclose your PHI to a public health oversight agency for authorized activities, including audits, civil, administrative or criminal investigations; inspections; licensure or disciplinary actions.

- **Coroner, Medical Examiner, or Funeral Director:** The Plan may disclose your PHI to a coroner or medical examiner for the purposes of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, the Plan may disclose your PHI to a funeral director, consistent with applicable law, as necessary to carry out the funeral director's duties.

- **Organ Donation:** The Plan may use or disclose your PHI to assist entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

- **Specified Government Functions:** In specified circumstances, federal regulations may require the Plan to use or disclose your PHI to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

- **Research:** The Plan may disclose your PHI to researchers when your individual identifiers have been removed or when an institutional review board or privacy board has reviewed the research proposal and established a process to ensure the privacy of the requested information and approves the research.

- **Disclosures to You:** When you make a request for your PHI, the Plan is required to disclose to you your medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan must also, when requested by you, provide you with an accounting of disclosures of your PHI if such disclosures were for any reason other than Treatment, Payment, or Health Care Operations (and if you did not authorize the disclosure).

Authorization to Use or Disclose Your PHI
Except as stated above, the Plan will not use or disclose your PHI unless it first receives written authorization from you. If you authorize the Plan to use or disclose your PHI, you may revoke that authorization in writing at any time, by sending notice of your revocation to the contact person named at the end of this section. To the extent that the Plan has taken action in reliance on your authorization (entered into an agreement to provide your PHI to a third party, for example) you cannot revoke your authorization.

Furthermore, the Plan will not: (1) supply confidential information to another company for its marketing purposes (unless it is for certain limited Health Care Operations); (2) sell your confidential information (unless under strict legal restrictions) (to "sell" means to receive direct or indirect remuneration); (3) provide your confidential information to a potential employer with whom you are seeking employment without your signed authorization; or (4) use or disclose psychotherapy notes unless required by law.

Additionally, if a state or other law requires disclosure of immunization records to a school, written authorization is no longer required. However, a covered entity still must obtain and document an agreement which may be oral and over the phone.

The Plan May Contact You
The Plan may contact you for various reasons, usually in connection with claims and payments and usually by mail.

Your Rights With Respect to Your PHI

- **Confidential Communication by Alternative Means**: If you feel that disclosure of your PHI could endanger you, the Plan will accommodate a reasonable request to communicate with you by alternative means or at alternative locations. For example, you might request the Plan to communicate with you only at a particular address. If you wish to request confidential communications, you must make your request in writing to the contact person named at the end of this section. You do not need to state the specific reason that you feel disclosure of your PHI might endanger you in making the request, but you do need to state whether that is the case. Your request also must specify how or where you wish to be contacted. The Plan will notify you if it agrees to your request for confidential communication. You should not assume that the Plan has accepted your request until the Plan confirms its agreement to that request in writing.

- **Request Restriction on Certain Uses and Disclosures:** You may request that the Plan restrict the uses and disclosures it makes of your PHI. This request will restrict or limit the PHI that is disclosed for Treatment, Payment, or Health Care Operations, and this restriction may limit the information that the Plan discloses to someone who is involved in your care or the payment for your care. The Plan is not required to agree to a requested restriction, but if it does agree to your requested restriction, the Plan is bound by that agreement, unless the information is needed in an emergency situation. There are some restrictions, however, that are not permitted even with the Plan's agreement. To request a restriction, please submit your written request to the contact person identified at the end of this section. In the request please specify: (1) what information you want to restrict; (2) whether you want to limit the Plan's use of that information, its disclosure of that information, or both; and (3) to whom you want the limits to apply (a particular physician, for example). The Plan will notify you if it agrees to a requested restriction on how your PHI is used or disclosed. You should not assume that the Plan has accepted a requested restriction until the Plan confirms its agreement to that restriction in writing. You may request restrictions on the Plan's use and disclosure of your confidential information for the treatment, payment and health care operations purposes explained in this section. Notwithstanding this policy, the Plan will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the Plan for purposes of carrying out payment or health care operations (and it is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider has been paid out-of-pocket in full.

- **Right to Be Notified of a Breach**: You have the right to be notified in the event that the Plan (or a Business Associate) discovers a breach of unsecured protected health information.

- **Electronic Health Records**: You may also request and receive an accounting of disclosures of electronic health records made for treatment, payment, or health care operations during the prior three years for disclosures made on or after (1) January 1, 2014 for electronic health records acquired before January 1, 2009; or (2) January 1, 2011 for electronic health records acquired on or after January 1, 2009. The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period.

- **Right to Access** Your PHI: You have a right to access your PHI in the Plan's enrollment, payment, claims adjudication and case management records, or in other records used by the Plan to make decisions about you, in order to inspect it and obtain a copy of it. Your request for access to this PHI should be made in writing to the appropriate contact person named at the end of this section. The Plan may deny your request for access, for example, if you request information compiled in anticipation of a legal proceeding. If access is denied, you will be provided with a written notice of the denial, a description of how you may exercise any review rights you might have, and a description of how you may complain to the Plan or the Secretary of Health and Human Services. If you request a copy of your PHI, the Plan may charge a reasonable fee for copying and, if applicable, postage associated with your request.

- **Right to Amend:** You have the right to request amendments to your PHI in the Plan's records if you believe that it is incomplete or inaccurate. A request for amendment of PHI in the Plan's records should be made in writing to the contact person named at the end of this section. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if, for example, your PHI in the Plan's records was not created by the Plan, if the PHI you are requesting to amend is not part of the Plan's records, or if the Plan determines the records containing your health information are accurate and complete. If the Plan denies your request for an amendment to your PHI, it will notify you of its decision in writing, providing the basis for the denial, information about how you can include information on your requested amendment in the Plan's records, and a description of how you may complain to the Plan or the Secretary of Health and Human Services.

- **Accounting:** You have the right to receive an accounting of certain disclosures made of your health information. Most of the disclosures that the Plan makes of your PHI are not subject to this accounting requirement because routine disclosures (those related to payment of your claims, for example) generally are excluded from this requirement. Also, disclosures that you authorize, or that occurred more than six years before the date of your request, are not subject to this requirement. To request an accounting of disclosures of your PHI, you must submit your request in writing to the applicable contact person named at the end of this section. Your request must state a time period which may not include dates more than six years before the date of your request. Your request should indicate in what form you want the accounting to be provided (for example on paper or electronically). The first list you request within a 12-month period will be free. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

- **Personal Representatives:** You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. The Plan retains discretion to deny a personal representative access to your PHI to the extent permissible under applicable law.

Complaints

If you believe that your privacy rights have been violated, you have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services. Any complaints to the Plan should be made in writing to the appropriate contact person named at the end of this section. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Information

- Archdiocese of Denver: For those Participating Entities located within the geographical territory of the Archdiocese of Denver, the Plan has designated Beth Link, as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this office at: The Archdiocese of Denver Management Corporation, 1300 S. Steele Street, Denver, CO 80210-2599 and 303-715-3196(phone)/303-715-2049 (fax).

- Diocese of Colorado Springs: For those Participating Entities located within the geographical territory of the Diocese of Colorado Springs, the Plan has designated Janet Hutchison as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at: 228 N. Cascade Ave., Colorado Springs, CO 80903, and 719-866-6462 (phone)/719-866-6463 (fax).

- Catholic Charities of the Archdiocese of Denver: For those Participants who are employees of Catholic Charities of the Archdiocese of Denver, the Plan has designated Tiffany Mackey as its contact person for all issues regarding the Plan's privacy practices and your privacy rights. You can reach this contact person at: Catholic Charities Denver, 4045 Pecos St., Denver, CO 80211 and 303-742-0828 (phone)/303-742-4431 (fax).

PLAN AMENDMENT AND TERMINATION INFORMATION

The Trustees of the Trust intend to maintain this Plan indefinitely; however, 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, is reserved to the Trust and its Trustees.

No person or entity has any authority to make any oral change or oral amendments to this Plan. No agent or representative of this Plan will have the authority to legally change Plan terms or this PD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to the Third Party Administrator within 75 days of the effective date of the termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

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

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

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

Acupuncture means a technique used to deliver anesthesia or analgesia, to treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Determination – see the Claims and Appeal Procedures section of this PD.

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 PD for the No Surprises Act requirements specific to air ambulance.

Ancillary Services means services rendered in connection with care provided to treat a medical condition whether scheduled or unscheduled, including, but not limited to: surgery, anesthesia, diagnostic testing, and imaging or therapy services. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency. With respect to the Protection from Balance Billing section, Ancillary Services means items and services provided by out-of-network Physicians at network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by an out-of-network Physician when a network Physician is not available.

Appeal – see the Claims and Appeal Procedures section of this PD.

Archdiocese means the Archdiocese of Denver, a Colorado corporation sole.

Archdiocese of Denver Welfare Benefits Trust is the trust established for the purpose of operating and maintaining welfare benefits plans, including this Plan, and administering contributions made by the Archdiocese of Denver, the Diocese of Colorado Springs, the parishes located within their respective territories, and certain other ecclesiastically related organizations, so as to provide welfare benefits to Participants and their Dependents in accordance with Catholic Church teachings.

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

Child (Children) means any of the following individuals with respect to a Participant: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Participant's or Spouse's Legal Guardianship; a foster Child; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Claim means any request for a benefit provided for under the Plan that is made by a Participant or his / her Dependent either by them or through their health care provider, which request complies with the Plan's reasonable procedures for making Claims for benefits. A Claim DOES NOT include a request for a determination of an individual's eligibility to participate in the Plan.

Close Relative means a member of the immediate family of a Participant. Immediate family includes the Participant, Spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, and grandchildren.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons, and does not promote the proper function of the body or prevent or treat an illness or injury.

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 PD.

Covered Person means a Participant or Dependent who is enrolled in this Plan.

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting 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 health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Day(s) or day(s) means calendar days, not business days (unless otherwise defined herein for purposes of a specific section).

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The applicable Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see the Eligibility section of this PD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills.

Diocese means the Diocese of Colorado Springs, a Colorado corporation sole.

Domestic Partner means an unmarried person of the same or opposite sex with whom the covered Participant shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It generally is not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

Educational Leave means leave that has been approved by a Participant's Participating Entity per that Participating Entity's internal policies (see the section herein entitled "TERMINATION").

Emergency means a serious medical condition, with acute symptoms that a Prudent Layperson would seek immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Experimental, Investigational, or Unproven means any drug, service, supply, care, 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 (i.e., that have not yet been 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 consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that 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, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care 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 means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution 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-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provides the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Foster Child means a child under age 26 who is placed with the Participant by an authorized placement agency or by judgement, decree, or other order of any court of competent jurisdiction.

Health Savings Account (HSA) (Applies to Benefit Plan(s) 009, 010) means a tax-exempt account administered by a qualified HSA trustee or custodian, established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a Qualified High Deductible Health Plan (QHDHP), has no other impermissible coverage under IRS rules, is not entitled to benefits under Medicare, and is not claimed as a Dependent on another person’s tax return. See Qualified High Deductible Health Plan (QHDHP).

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; 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 mean 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.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person 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 per day, 7 days per 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, Physician services, physical or occupational therapy, 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;
- 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 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, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate. The term "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.

Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

Incurred or Incur(s) means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed 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 performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at 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 Guardian means a Participant recognized by a court of law as having the duty of taking care of and managing the property and rights of a minor child.

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

Manipulation means chiropractic care, skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from or related to distortion, misalignment or subluxation of, or in the vertebral column.

Marriage or marriage shall be between a man and a woman consistent with the universal and particular law of the Catholic Church, and shall include a civil law common law marriage that must be attested to by submission to the Plan Administrator of a fully executed affidavit utilizing a form approved by the Plan Administrator.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by 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 Participant 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; and
- 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 experts 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 will 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 the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

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.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Orthognathic means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally 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 for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Participant means an individual who has met the Plan's Participant eligibility requirements as defined in the section entitled Eligibility and who has enrolled in the Plan.

Participating Entity(ies) means the Archdiocese, the Diocese, and those eligible entities that participate in the Plan pursuant to the terms of the Trust, and for whom Participants either work, with whom Participants are associated (select classes of clerics), or with whom Participants have enrolled as seminary students.

PD means this Archdiocese of Denver Welfare Benefits Trust Self-Funded Medical Plan Document.

Person Eligible to Participate – see the section entitled Eligibility

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he/she practices.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: a doctor of medicine (MD), doctor of medical dentistry, including an oral surgeon (DMD), doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed for Adoption 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 the Archdiocese of Denver Welfare Benefits Trust Self-Funded Medical Plan consisting of the various Plan Benefits Options listed in the Medical Schedule of Benefits section herein.

Plan Administrator means The Archdiocese of Denver Management Corporation.

Plan Benefits Options means those benefit option packages available under the Plan that Participants and their Dependents may choose from upon enrolling in the Plan. See the Schedule of Benefits specific to each Plan Benefits Option in the section entitled Medical Schedule of Benefits.

Plan Document or PD means this Archdiocese of Denver Welfare Benefits Trust Self-Funded Medical Plan Document.

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

Plan Fiscal Year means the period beginning July 1 and ending June 30 of each year. The Plan Fiscal Year is used for purposes of open enrollment, premium adjustments, and the ACA standard stability period.

Plan Year means the period beginning January 1 and ending December 31 of each year. The Plan Year is used for purposes of Deductibles, Co-pays, Plan Participation, and out-of-pocket maximums.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Prescription Drug(s) means any of the following: an FDA-approved drug or medicine which, under federal law, is required to bear the legend: “Caution: federal law prohibits dispensing without prescription”; injectable insulin; allergy immunotherapy; hypodermic needles or syringes, but only when dispensed upon a written prescription of a Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

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 applicable Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

(Applies to Benefit Plan(s) 009, 010) For a Qualified High Deductible Health Plan (QHDHP), Preventive / Routine Care means care consistent with IRS Code §223(c)(2)(c) and as listed in the Schedule of Benefits, that may be paid by a QHDHP without the Covered Person satisfying the minimum Deductible under the Plan.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified High Deductible Health Plan (QHDHP) (Applies to Benefit Plan(s) 009, 010) means a health plan that meets the IRS requirements of a High Deductible Health Plan with respect to Deductibles and out-of-pocket amounts for the purpose of being able to contribute to a Health Savings Account (HSA). See Health Savings Account (HSA).

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

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 Co-pays, 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 Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Sabbatical Leave means leave that has been approved by a Participant's Participating Entity to promote a Participant's intellectual and spiritual growth (see the section herein entitled "TERMINATION).

Schedule(s) of Benefits means the list of benefits (including Copays, Deductible, etc.) provided for under the Plan and that are specific to a Plan Benefits Option.

Short Term Disability means an Injury or Illness that keeps a person from work for a temporary period of time not to exceed twenty-six (26) weeks.

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, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who 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.

Spouse has the meaning ascribed to it in the section herein entitled "ELIGIBILITY".

Substance Use Disorder is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

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 a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It 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.

Temporomandibular Joint (TMJ) Syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

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

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services.

Totally Disabled means, as determined by the Plan in its sole discretion:

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

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

Trust means the Archdiocese of Denver Welfare Benefits Trust.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

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

Waiting Period means the period of time that must pass before coverage becomes effective for an individual who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility section of the Plan to determine whether a Waiting Period applies.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You / Your means a Participant.