COLUMBIA PUBLIC SCHOOL DISTRICT
COLUMBIA MO

Health Benefit Summary Plan Description
7670-00-414028

BENEFITS ADMINISTERED BY

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 001

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

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

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

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

	IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation:		
Ground:		
Paid By Plan After In-Network Deductible	80%	80%
Air:		
Maximum Benefit Per Occurrence	$25,000	
Paid By Plan After In-Network Deductible	80%	80%
Autism - Refer To The Covered Medical Benefits Section For Details:		
Autism Services:		
Paid By Plan After Deductible	80%	70%
ABA Therapy:		
To Age 19		
Maximum Benefit Per Calendar Year	$45,853	
Paid By Plan After Deductible	80%	70%
Note: Limit Will Be Adjusted Every 3 Years In Accordance With Missouri State Law HB 1311.		
Breast Pumps:		
Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Contraceptive Methods And Contraceptive Counseling Approved By The FDA:		No Benefit
For Men:		
Paid By Plan After Deductible	80%	
For Women:		
Paid By Plan	100% (Deductible Waived)	
Durable Medical Equipment:		
Paid By Plan After Deductible	80%	70%

	IN-NETWORK	OUT-OF-NETWORK
Home Health Care Benefits: Paid By Plan After Deductible	80%	70%

Note: A Home Health Care Visit Will Be Considered A Pe

	IN-NETWORK	OUT-OF-NETWORK
Maternity: **Routine Prenatal Services:** Paid By Plan After Deductible	100% (Deductible Waived)	70%
Non-Routine Prenatal Services, Delivery, And Postnatal Care: Paid By Plan After Deductible	80%	70%
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits: Paid By Plan After Deductible	80%	70%
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**		

	IN-NETWORK	OUT-OF-NETWORK
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum Paid By Plan	100% (Deductible Waived)	No Benefit

	IN-NETWORK	OUT-OF-NETWORK
Sterilizations: **For Men:**		

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 002, 003

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, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

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

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

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 Family Coverage ***Note: If Family Coverage Is Elected, The Full Family Deductible Amount Must Be Met Before The Plan Will Begin Paying At The Plan Participation Level.***	 $2,000 $4,000	 $2,000 $4,000
Plan Participation Rate, Unless Otherwise Stated Below: Paid By Plan After Satisfaction Of Deductible	 100%	 70%
Annual Total Out-Of-Pocket Maximum: ***Note: Medical And Pharmacy Expenses Are Subject To The Same Out-Of-Pocket Maximum.*** Single Coverage Family Coverage ***Note: If Family Coverage Is Elected, The Full Family Out-Of-Pocket Maximum Amount Must Be Met Before The Plan Will Begin Paying Covered Expenses In Full.***	 $4,000 $6,000	 $8,000 $16,000

	IN-NETWORK	OUT-OF-NETWORK
Home Health Care Benefits:		

	IN-NETWORK	OUT-OF-NETWORK
Maternity:		
Routine Prenatal Services:		
Paid By Plan After Deductible	100% (Deductible Waived)	70%
Non-Routine Prenatal Services, Delivery, And Postnatal Care:		
Paid By Plan After Deductible	100%	70%
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits:		
Paid By Plan After Deductible	100%	70%
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	100%	70%
Physician Office Services:		
Paid By Plan After Deductible	100%	70%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
Preventive / Routine Physical Exams At Appropriate Ages:		No Benefit
Paid By Plan	100% (Deductible Waived)	
Immunizations:		No Benefit
Paid By Plan	100% (Deductible Waived)	
Note: Foreign Travel Immunizations Are Not Covered.		
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:		No Benefit
Paid By Plan	100% (Deductible Waived)	
Preventive / Routine Mammograms And Breast Exams:		No Benefit
Maximum Exams Per Calendar Year Including 3D Mammograms For Preventive Screenings	1 Exam	
Paid By Plan	100% (Deductible Waived)	

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) 001	
Transplant Services At A Designated Transplant Facility:	
Transplant Services:	
Paid By Plan After Deductible	80%
Travel And Housing:	
Maximum Benefit Per Transplant	$10,000

TRANSPLANT SCHEDULE OF BENEFITS

OUT-OF-POCKET EXPENSES AND MAXIMUMS

The eligible out-of-pocket expenses that the Covered Person Incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person Incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-

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payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 002, 003

DEDUCTIBLES

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provi -of- -of-pocket

payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

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If You are a Retired Employee eligible

A Dependent does not include the following:

A grandchild;
A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
Any other relative or individual unless explicitly covered by this Plan.

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

Eligibility Criteria: 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 reside with the Employee. This residency requirement does not apply to Children who are full-time students living away from home to attend school, to Children who reside in institutions, or to Children who are enrolled in accordance with a

A Totally Disabled Dependent Child age 26 or over must be dependent upon the Employee 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 Qualified Medical Child Support Order because of the Employee's divorce or separation decree.
A Totally Disabled Dependent Child age 26 or over must be unmarried.

NON-

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 or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

Note: Retirees are eligible for special enrollment rights due to loss of coverage as long as it is within 12 months of the last day of employment. Similarly, Retirees not currently participating in the Plan are eligible to enroll themselves and their Dependents upon acquisition of a new Dependent as long as it is within 12 months of the last day of employment.

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 should notify CPS Employee Benefits 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:

COBRA continuation coverage and that coverage was exhausted; or
Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
Terminated and no substitute coverage was offered; or
No longer receiving any monetary contribution toward the premium from the employer.

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

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

You or Your Dependents 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 employer no longer contributed any money toward the premium for that coverage.

NEWLY ELIGIBLE FOR PREMIUM INSURANCE PROGRAM

A current Employee and his or her Dependents may be eligible for a special enrollment period if the

plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status. Retired Employees participating in this Plan are eligible to enroll a Dependent acquired through marriage, birth, adoption or Placement for Adoption as long as the Retiree requests and applies for coverage for such Dependent within 31 calendar days of the marriage, birth, adoption, or Placement for Adoption as long as it is within 12 months of the last day of employment.

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

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 their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or

In the case of a Dependent's birth, on the date of such birth; or

In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or

plan, on the date the approved request for coverage is received; or

In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the

information.

TERMINATION

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

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 at annual open enrollment periods; or

The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:

If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to the end of the month in which the earliest of the following dates in the case of Your ending of active

REINSTATEMENT OF COVERAGE

COBRA CONTINUATION OF COVERAGE

Note:

(There are two ways in which this 18-month period of COBRA continuation coverage may be extended.

more information.)

The spouse of an Employee 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 Employee dies	up to 36 months
	up to 18 months

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation cover

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

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

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

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

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

The Qualified Beneficiary must give the COBRA administrator a copy of 20(r)12( )-7(a)20( )-7(co)20(p)-14(y)36( )-7(o)20/tE

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace,

Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

EARLY TERMINATION OF COBRA CONTINUATION

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

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

expressed in the COBRA regulations.

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

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

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

Termination for cause, such as submitting fraudulent claims.

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

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

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the In-Network benefit level by the prior claims administrator, but that are not considered at the In-Network benefit level by the current claims administrator, may be paid at the applicable In-Network benefit level if the Covered Person is currently
ious PPO but who is not a
In order to ensure
continuity of care for certain medical conditions already under treatment, the In-Network medical plan benefit level may continue for 120 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

Cancer if under active treatment with chemotherapy and/or radiation therapy.
Organ transplants for patients under active treatment (e.g., seeing a Physician on a regular basis, being on a transplant waiting list, or being ready at any time for a transplant).

Post-acute Injury or surgery within the past three months.
Pregnancy in the second or third trimester and up to eight weeks postpartum.
Behavioral health (any previous treatment).

You or Your Dependent must call UMR within 30 days prior to Your Effective Date or within 30 days after Your Effective Date to see if You or Your Dependent is eligible for this benefit.

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

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 SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Pe
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. Failure to obtain prior authorization may result in a penalty or increased out-of-

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), or for treatment of cleft palate, 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 as 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

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

28. **Genetic Testing or Genetic Counseling in relation to Genetic Testing** based on Medically Necessary.

    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

    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.

29. **Hearing Services** include:

    Exams, tests, services, and supplies to diagnose and treat a medical condition.
    Implantable hearing devices require Medical Necessity review.

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

31. **Hospice Care Services:** Treatment given at a Hospice Care facility must be in place of a stay in a Hospital or Extended Care Facility, and 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 ervd(se)236(,4( )-7(c)3

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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.

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

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

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.

33. **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.

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

35. **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. Once the patient is receiving fertility treatment to achieve pregnancy, diagnostic tests and treatments are then considered part of the infertility benefit.

Covered Infertility Treatment includes genetic testing to diagnose infertility.

36. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits. Charges by a pathologist for interpretation of computer-generated automated laboratory test reports are not covered by the Plan.

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

38. **Maternity Benefits** for the Employee or spouse include:

Hospital or Birthing Center room and board.
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39.

49. **Oxygen and Its Administration.**

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

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

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

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

54. **Prescription Medications** 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

    pharmacy, which are covered under the Prescription benefit.

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

    The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a

56.

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.

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 his or her 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.

Scheduling: Teladoc will provide the Covered Person with information identifying each behavioral health

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

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

TRANSPLANT BENEFITS

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

The program for Transplant Services at Designated Transplant Facilities is:

Optum

This coverage provides You with a choice for transplant care. The Plan provides incentives to You and Your covered Dependents by giving You the option of using a Designated Transplant Facility. While the Plan does not require You to use a Designated Transplant Facility in order to receive benefits You may receive better benefits if You do so. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outco(t)-7(y)36(2iB(g)20(n)-14(a)20(t)-7(e)20(d)-14(8( )-7(p)-14(a)20(t)-7(i)8(e)20

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of

PRESCRIPTION DRUG BENEFITS

Administered by ESI

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

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare-eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. A Medicare-eligible individual generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to obtain Prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay additional monthly penalties if they change their minds and sign up later. Medicare-eligible individuals should have received notices informing them of whether or no

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

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.

CARE MANAGEMENT

Utilization Management

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

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within

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. This does not apply to COBRA participants. See continuation coverage below. 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 ben

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

If
Primary Plan is the plan that has covered the person for the longer period of time. In the event the

s
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
c
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, .07 29BDC BT5tble for theirtrentraty have been m

Medicare generally pays first under the following circumstances:

You are no longer actively employed by an employer; and

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

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

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

Upon 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.

under these provisions, including, but not limited to, providing or exchanging medical payment information

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.
will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

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

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

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

In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan

19. **Court**

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

34. **Genetic Testing or Genetic Counseling,** unless covered elsewhere in this SPD.

35. **Growth Hormones.**

36. **Hazardous Recreational Activity:** Injuries or Illnesses related to Hazardous Recreational Activities, unless the Injuries or Illnesses are caused primarily as a result of other medical conditions not related to the Hazardous Recreational Activities, or to domestic violence.

37. **Hearing Services:** Purchase or fitting of hearing aids unless covered elsewhere in this SPD.

38. **Home Births** and associated costs.

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:**

    Surgical reversal of a sterilized state that was a result of a previous surgery.

    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,** unless covered elsewhere in this SPD.

46. **Maintenance Therapy** if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if 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 SPD.

48. **Marriage Counseling.**

49. **Massage Therapy.**

50. **Maternity Other Than Routine Prenatal Medical Care Expenses** for Covered Persons other than the Employee or spouse or Domestic Partner.

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

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

72. **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.

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

74. **Services Provided By a School**.

75. **Sex Therapy.**

76. **Sexual Function:** Diagnostic service, non-

89. **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.

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

91. **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 SPD.

92. An Illness or Injury arising out of, or in the course of, any employment for wage or profit, not including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker Compensation, U.S. Longshoremen and Harbor Worker or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force. If You are an Employee with a second job or if You are covered as a Dependent under this Plan and You are self-employed or employed by an employer that does not provide health benefits, Your claims may not be covered by the health plan. You will need to have other medical benefits to provide for Your medical care in the event that You are hurt on the job. In most cases,
coverage You may end up with no coverage at all.

93. **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

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

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered
ordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

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

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

nd relationship to Employee
Authorized signature from the Covered Person
Diagnosis
Date of service
Place of service
Procedures, services, or supplies (narrative description)
Charges for each listed service
Number of days or units
if applicable)
Total billed charges

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a

is a Personal Representative.

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

The Covered Person must file the appeal within 180 days of the date

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

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

UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

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

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

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

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

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

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

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

forwarded to the IRO, together with:

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

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

iting and will include the clinical basis for the determination. The IRO will provide You and UMR and/or
qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

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

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

FRAUD

Fraud is a crime 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 SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA 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 COBRA. (Please note that the examples listed are not all-inclusive.)

coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

member, files claims on the Co
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

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

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 tes

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

Contributions are paid; and

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

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

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may,

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 an Employee: a natural biological Child; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or s Legal Guardianship; a Child of a Domestic Partner, a

Domestic Partner / Domestic Partnership means an unmarried person of the same or opposite sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the 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, and a person whom you have been living in a marriage like relationship for at least a year.

In order for Your Domestic Partner to qualify as a Dependent, You and Your partner must complete an certification declaring that You and Your partner:

welfare;
Have maintained this relationship for the past six months and intend to do so indefinitely;
Have shared a primary residence for the past six months and intend to do so indefinitely;
Are not married to anyone else and do not have other Domestic Partners;
Are financially interdependent.

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 is generally not useful to a person in the absence of an Illness or Injury.
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A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

For anyone who applies for coverage when first eligible, the first day of the Waiting Period.
(Applies to non-exempt hourly Employees)
For anyone who applies for coverage when first eligible, the date that coverage begins.
(Applies to exempt salaried Employees)
For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

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;

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

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion 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 a disorder that is a clinically significant psychological syndrome associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness, or death.

Motor Vehicle Collision means an Accident that occurs when a motor vehicle strikes or collides with another vehicle, a stationary object, a pedestrian, or an animal with no implied determination of fault.

Morbid Obesity means a Body Mass Index (BMI) that is greater than or equal to 40 kg/m2. If there are serious (life-threatening) medical condition(s) exacerbated by, or caused by, obesity not controlled despite maximum medical therapy and patient compliance with a medical treatment plan, a BMI greater than or equal to 35 kg/m2 is applied. Morbid Obesity for a Covered Person who is less than 19 years of age means a BMI that falls above the 95th percentile on the growth chart.

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 Condition 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

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.

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

Physician means any of the following licensed practitioners, acting within the scope of 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 osteo

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. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or

That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Diagnosis of one or more of the following conditions is not considered proof of total disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the most recent revision of the International Classification of Diseases Clinical Modification manual (ICD-CM) in the following categories: