

City of Columbia

701 East Broadway, Columbia, Missouri 65201



Agenda Item Number: B 362-14

Department Source: Human Resources

To: City Council

From: City Manager & Staff

Council Meeting Date: November 17, 2014

Re: Adopt 2015 Active Employee, Non-Medicare Retiree, Medicare Retiree and COBRA Health, Dental, Vision and Medicare Supplement Premium Rates. Adopt 2015 medical and dental summary plan documents, effective January 1, 2015. Amend 19-110(a) health benefit eligibility.

Documents Included With This Agenda Item

Council memo, Resolution/Ordinance, Exhibits to Resolution/Ordinance

Supporting documentation includes: None

Executive Summary

The proposed ordinance adopts medical, dental, COBRA, vision and Medicare supplement plan premium rates for plan year 2015. The proposal includes the annual adoption of the City's self-funded medical and dental insurance plan summary plan documents. 19-110(a) is amended to extend eligibility to participate in the City's health care plan to comply with Affordable Care Act (ACA) requirements.

Discussion

The annual health plan review and cost projection for 2015 determines premium requirements for plan year 2015. No premium increases will be imposed on the active employee, COBRA, or non-Medicare retiree rates under the City self-funded plan. No premium increase will be imposed in the City self-funded dental plan.

The City will continue to pay the full cost of employee health insurance premiums in the High Deductible Health Plan (HDHP). The City will continue contributions to Health Savings Accounts (HSAs) under the HDHP: \$125 per month for employee only coverage, and \$250 per month for family coverage. All employees will pay a portion of their health insurance premiums for the \$750 and \$1,500 deductible plans.

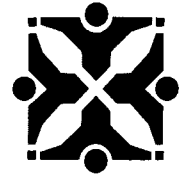
The Medicare retiree plan is a City sponsored, fully insured Medicare Plan F/Part D product. Medicare retiree rates are determined through the renewal process with United American. Rates for 2015 increase \$14 to \$28 per month.

No plan design changes will be made in any self-funded plan, or in the Medicare Plan F/Part D plan.

Rate charts for active employee health dental and vision, COBRA, non-Medicare retiree, and Medicare supplemental plans are included with this ordinance. The rates are effective January 1,

City of Columbia

701 East Broadway, Columbia, Missouri 65201



2015.

The proposed ordinance also adopts the City 2015 medical plan summary documents for the \$750 and \$1,500 deductible plans, the High Deductible Health Plan, which includes a Health Savings Account, and the dental plan. No changes in plan design will be made in 2015. Plan documents are included with this ordinance. The plans are effective January 1, 2015.

19-110(a) would be amended to extend eligibility to participate in the City's health care plan to comply with Affordable Care Act (ACA) requirements for coverage starting January 1, 2015. The ACA requires the City to offer healthcare coverage to any employee who works an average of 30 hours per week/130 hours per month.

Fiscal Impact

Short-Term Impact: The City's health plan costs and premium revenues are reflected in the Employee Benefit Fund budget, adopted in the City of Columbia FY 2015 budget. These funds are used to pay medical, dental and prescription drug claims in the self-funded plan incurred by plan participants; to pay VSP for the fully insured vision plan; and to pay United American premiums the City bills to Medicare retirees for the fully insured Medicare supplemental plan. Estimates for health care costs for temporary employees who average 30 hours or more of work per week/130 hours per month are also included in the FY 2015 adopted budget.

Long-Term Impact: Unknown.

Vision, Strategic & Comprehensive Plan Impact

Vision Impact: Governance and Decision Making

Strategic Plan Impact: Financial Health

Comprehensive Plan Impact: Not Applicable

Suggested Council Action

Adoption of the proposed ordinance.

Legislative History

Not applicable.


Department Approved


City Manager Approved

Introduced by _____

First Reading _____

Second Reading _____

Ordinance No. _____

Council Bill No. B 362-14

AN ORDINANCE

establishing plan year 2015 active employee and COBRA medical, dental and vision premium rates, and non-Medicare medical, retiree dental and Medicare retiree medical and dental premium rates; providing for payroll withholdings; adopting the Choice Plus \$750 Plan, the Choice Plus \$1,500 Plan, the Choice Plus \$2,500 High Deductible Health Plan and the Group Dental Plan for the City of Columbia; and fixing the time when this ordinance shall become effective.

BE IT ORDAINED BY THE COUNCIL OF THE CITY OF COLUMBIA, MISSOURI, AS FOLLOWS:

SECTION 1. The City Council hereby establishes plan year 2015 premium rates for the following plans as set forth in "Exhibits A – F" attached hereto and made a part hereof:

Active Employee Medical
Active Employee Dental
Active Employee Vision
COBRA Medical, Dental and Vision
Non-Medicare Medical and Retiree Dental
Medicare Retiree Medical and Dental

SECTION 2. The active employees' portion of the group insurance premiums shall be withheld from employees' pay in the month of coverage.

SECTION 3. The new premiums set forth in Section 1 shall take effect on January 1, 2015.

SECTION 4. The City Council adopts the Choice Plus \$750 Plan for the City of Columbia, a copy of which is in substantially the same form as set forth in "Exhibit G" attached hereto.

SECTION 5. The City Council adopts the Choice Plus \$1,500 Plan for the City of Columbia, a copy of which is in substantially the same form as set forth in "Exhibit H" attached hereto.

SECTION 6. The City Council adopts the Choice Plus \$2,500 High Deductible Health Plan for the City of Columbia, a copy of which is in substantially the same form as set forth in "Exhibit I" attached hereto.

SECTION 7. The City Council adopts the Group Dental Plan for the City of Columbia, Missouri, a copy of which, marked "Exhibit J," is attached to and made a part of this ordinance.

SECTION 8. The Choice Plus Plans adopted in Sections 4, 5 and 6 and the Group Dental Plan adopted in Section 7 shall take effect on January 1, 2015 and the plans replace the 2014 Choice Plus Plans and 2013 Group Dental Plan.

SECTION 9. This ordinance shall be in full force and effect from and after its passage.

PASSED this _____ day of _____, 2014.

ATTEST:

City Clerk

Mayor and Presiding Officer

APPROVED AS TO FORM:

City Counselor

CITY OF COLUMBIA				
GROUP INSURANCE PLAN - 2015 ACTIVE EMPLOYEE RATES				
\$750 CO-PAY PLAN (Effective 1/1/2015)				
2015 Medical Coverage	Gross Rate	City Contribution	Net Monthly Rate	Net Bi-Weekly Rate
Single	\$ 436.41	\$ 394.60	\$ 41.81	\$ 20.91
Single + Spouse	\$ 895.71	\$ 494.28	\$ 401.43	\$ 200.72
Single + Child(ren)	\$ 729.87	\$ 460.70	\$ 269.17	\$ 134.59
Full Family	\$ 1,276.44	\$ 634.97	\$ 641.47	\$ 320.74
Married/Dom Partners w/ full family coverage	\$ 638.22	\$ 514.79	\$ 123.44	\$ 61.72
\$750 individual deductible		\$2,250 family deductible		
\$1500 CO-PAY PLAN (Effective 1/1/2015)				
2015 Medical Coverage	Gross Rate	City Contribution	Net Monthly Rate	Net Bi-Weekly Rate
Single	\$ 408.22	\$ 394.60	\$ 13.62	\$ 6.81
Single + Spouse	\$ 779.16	\$ 487.80	\$ 291.36	\$ 145.68
Single + Child(ren)	\$ 636.05	\$ 456.40	\$ 179.65	\$ 89.83
Full Family	\$ 1,103.09	\$ 619.34	\$ 483.75	\$ 241.88
Married/Dom Partners w/ full family coverage	\$ 1,103.09	\$ 1,013.94	\$ 44.58	\$ 22.29
\$1500 individual deductible		\$4500 family deductible		
\$2500 HDHP PLAN (Effective 1/1/2015)				
2015 Medical Coverage	Gross Rate	City Contribution	Net Monthly Rate	Net Bi-Weekly Rate
Single (Employer Paid)	\$ 394.60	\$ 394.60	\$ -	\$ -
Single + Spouse	\$ 753.18	\$ 487.80	\$ 265.38	\$ 132.69
Single + Child(ren)	\$ 614.91	\$ 456.40	\$ 158.51	\$ 79.26
Full Family	\$ 1,066.13	\$ 619.34	\$ 446.79	\$ 223.40
Married/Dom Partners w/ full family coverage	\$ 1,076.97	\$ 1,013.94	\$ 31.52	\$ 15.76
\$2500 individual deductible		\$5000 family deductible		

CITY OF COLUMBIA				
GROUP INSURANCE PLAN - 2015 ACTIVE EMPLOYEE RATES				
2015 Dental Coverage				
2015 Medical Coverage	Gross Rate	City Contribution	Net Monthly Rate	Net Bi-Weekly Rate
Single (Employer Paid)	\$ 33.12	\$ 33.12	\$ -	\$ -
Spouse	\$ 66.06	\$ 33.12	\$ 32.94	\$ 16.47
Children	\$ 66.06	\$ 33.12	\$ 32.94	\$ 16.47
Full Family	\$ 98.94	\$ 33.12	\$ 65.82	\$ 32.91
Married/Dom Partners w/ full family coverage	\$ 49.47	\$ 33.12	\$ 16.35	\$ 8.18
\$25 deductible for each individual				

CITY OF COLUMBIA				
2015 VISION PLAN - ACTIVE EMPLOYEE RATES				
2015 Vision Coverage			Monthly Rate	Per Bi-Weekly Paycheck
Single			\$ 8.06	\$ 4.03
Single + Spouse			\$ 16.13	\$ 8.07
Single + Child(ren)			\$ 17.25	\$ 8.63
Full Family			\$ 27.60	\$ 11.25
Fully Insured Through VSP				

City of Columbia 2015 COBRA RATES	
\$750 Deductible Plan (Effective 1/1/2015)	
2015 Medical Coverage	Monthly Premium
Single	\$ 445.14
Single + Spouse	\$ 913.62
Single + Child(ren)	\$ 744.47
Full Family	\$ 1,301.97
Child(ren) only	\$ 305.32
\$750 Individual deductible \$2250 Family deductible	
\$1500 Deductible Plan (Effective 1/1/2015)	
2015 Medical Coverage	Monthly Premium
Single	\$ 416.38
Single + Spouse	\$ 794.74
Single + Child(ren)	\$ 648.77
Full Family	\$ 1,125.15
Child(ren) only	\$ 237.03
\$1500 Individual deductible \$4500 Family deductible	
\$2500 High Deductible Health Plan (1/1/2015)	
2015 Medical Coverage	Monthly Premium
Single	\$ 402.49
Single + Spouse	\$ 768.24
Single + Child(ren)	\$ 627.21
Full Family	\$ 1,087.45
Child(ren) only	\$ 229.21
\$2500 Individual deductible \$5000 Family deductible	
Dental Coverage (Effective 1/1/2015)	
20145 Dental Coverage	Monthly Premium
Single	\$ 33.78
Single + Spouse	\$ 67.38
Single + Child(ren)	\$ 67.38
Full Family	\$ 100.92
Child(ren) only	\$ 33.60
\$25 deductible for each individual	
Vision Coverage (Effective 1/1/2015)	
2015 Vision Coverage	Monthly Premium
Single	\$ 8.22
Single + Spouse	\$ 16.45
Single + Child(ren)	\$ 17.60
Full Family	\$ 28.15
Fully Insured Through VSP	

City Of Columbia GROUP INSURANCE PLAN 2015 NON-MEDICARE MEDICAL RATES		
\$750 Co-Pay Plan (Effective 1/1/2015)		
2015 Medical Coverage	Monthly Premium	
Single	\$	676.44
Single + Spouse	\$	1,379.94
Single + Children	\$	1,122.90
Full Family	\$	1,961.68
\$750 individual deductible		\$2,250 family deductible
\$1500 Co-Pay Plan (Effective 1/1/2015)		
2015 Medical Coverage	Monthly Premium	
Single	\$	652.76
Single + Spouse	\$	1,331.64
Single + Children	\$	1,083.60
Full Family	\$	1,893.02
\$1500 individual deductible		\$4500 family deductible
High Deductible Health Plan (Effective 1/1/2015)		
2015 Medical Coverage	Monthly Premium	
Single	\$	632.47
Single + Spouse	\$	1,290.24
Single + Children	\$	1,049.91
Full Family	\$	1,834.17
\$2500 individual deductible		\$5000 family deductible

City Of Columbia 2015 RETIREE DENTAL RATES (Effective 1/1/2015)		
2015 Dental Coverage	Monthly Dental Premium	
Single	\$	33.12
Single + Spouse	\$	66.06
Single + Children	\$	66.06
Full Family	\$	98.94
\$25 deductible for each individual		

City Of Columbia MEDICARE RETIREE RATES			
2015 Medical Coverage		Monthly Premium	
Single		\$	336.00
Single + <65 Spouse		\$	1,012.44
Single + >65 Spouse		\$	672.00
Single + Children		\$	917.74
Full Family (Spouse <65)		\$	1,594.18
Full Family (Spouse >65)		\$	1,253.74
Medicare Supplemental Plan Fully Insured Through United American			
<p>GROUP INSURANCE PLAN - 2015 MEDICARE RETIREE RATES Dental Coverage Only</p>			
2015 Dental Coverage		Monthly Premium	
Single		\$	33.12
Single + Spouse		\$	66.06
Single + Children		\$	66.06
Full Family		\$	98.94
\$25 deductible for each individual			

Summary Plan Description

City of Columbia, Missouri Choice Plus \$750 Plan

Effective: January 1, 2015
Group Number: 704919



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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Care CoordinationSM and Mental Health/Substance Use Disorder Administrator: (866) 844-4864;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: www.myuhc.com.

City of Columbia, Missouri is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

City of Columbia, Missouri intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. City of Columbia, Missouri is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- City of Columbia, Missouri is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full time employee of the Plan Sponsor, a permanent part-time employee, a non-Medicare eligible retiree, a Spouse of a Medicare eligible retiree under 65 and covered under The Company sponsored Medicare Plan, and a surviving Spouse.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and City of Columbia, Missouri share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of City of Columbia, Missouri's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and City of Columbia, Missouri reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days from your date of hire for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date Human Resources receives notice of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in City of Columbia, Missouri's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under City of Columbia, Missouri's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

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

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

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

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Care CoordinationSM, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of City of Columbia, Missouri or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Eligible Expenses

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

Eligible Expenses are the amount the Claims Administrator determines that the Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network

Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
 - ◆ For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
 - ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claims Administrator will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

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

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

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

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays, even those for Covered Health Services available in Section 15, <i>Prescription Drugs</i>	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Care Coordination SM	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - CARE COORDINATIONSM

What this section includes:

- An overview of the Care CoordinationSM program; and
- Covered Health Services for which you need to contact Care CoordinationSM.

UnitedHealthcare provides a program called Care CoordinationSM designed to encourage personalized, efficient care for you and your covered Dependents.

Care CoordinationSM nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Care CoordinationSM nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

Care CoordinationSM nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Care CoordinationSM program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Care CoordinationSM nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, a Care CoordinationSM nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care CoordinationSM nurse to confirm that medications, needed equipment, or follow-up services are in place. The Care CoordinationSM nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care CoordinationSM nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care CoordinationSM nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Requirements for Notifying Care CoordinationSM

Network providers are generally responsible for notifying Care CoordinationSM before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Care CoordinationSM.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying Care CoordinationSM before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if Care CoordinationSM is not notified.

The services that require Care CoordinationSM notification are:

- breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature;
- Clinical Trials;
- Congenital Heart Disease services;
- Durable Medical Equipment for items that will cost more than \$1,000 to purchase or rent;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay;
- maternity care that exceeds the delivery timeframes as described in Section 6, *Additional Coverage Details*;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - Autism Spectrum Disorder Services -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Pre-service notification is also required for Benefits provided for Applied Behavioral Analysis (ABA).
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment;

psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; and

- transplantation services.

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

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

Notification is required within one business day of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For notification timeframes, and reductions in Benefits that apply if you do not notify Care CoordinationSM, see Section 6, *Additional Coverage Details*.

Contacting Care Coordination is easy.

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

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Care CoordinationSM before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network	Non-Network
Copays¹		
■ Emergency Health Services	\$200	\$200
■ Physician's Office Services - Primary Physician	\$15	Not Applicable
■ Physician's Office Services - Specialist	\$30	Not Applicable
■ Urgent Care Center Services	\$35	Not Applicable
Annual Deductible²		
■ Individual	\$750	\$2,250
■ Family (not to exceed the individual Annual Deductible amount per Covered Person)	\$2,250	\$6,750
Annual Out-of-Pocket Maximum²		
■ Individual	\$3,000	\$9,000
■ Family (not to exceed the individual Annual Out-of-Pocket Maximum amount per Covered Person)	\$9,000	\$27,000
Lifetime Maximum Benefit³ There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

¹In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services, a Copay does not apply when you visit a non-Network provider.

²Copays apply toward the Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

³Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:

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

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Ambulance Services - Emergency Only	<i>Ground Transportation</i> 80% after you meet the Annual Deductible <i>Air Transportation</i> 80% after you meet the Annual Deductible	<i>Ground Transportation</i> 80% after you meet the Annual Deductible <i>Air Transportation</i> 80% after you meet the Annual Deductible
Cancer Resource Services (CRS)² ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	Not Covered
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Durable Medical Equipment (DME)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Emergency Health Services If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a \$200 Copay	
Eye Examinations	100% after you pay a \$30 Copay	60% after you meet the Annual Deductible
Home Health Care Up to 50 visits per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care Up to 360 days per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Injections received in a Physician's Office	Allergy injections: 80% per injection Immunizations: 100% per injection	60% per injection after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	80% after you meet the Annual Deductible	Not Covered
Maternity Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Mental Health Services <ul style="list-style-type: none"> ■ Hospital - Inpatient Stay ■ Physician's Office Services (Copay is per visit) 	80% after you meet the Annual Deductible 100% after you pay a \$15 Copay	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services <ul style="list-style-type: none"> ■ Hospital - Inpatient Stay ■ Physician's Office Services (Copay is per visit) 	80% after you meet the Annual Deductible 100% after you pay a \$15 Copay	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Obesity	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Outpatient Surgery, Diagnostic and Therapeutic Services <ul style="list-style-type: none"> ■ Outpatient Surgery ■ Outpatient Diagnostic Services <ul style="list-style-type: none"> - Preventive Lab and radiology/X-ray - Preventive mammography testing (One per calendar year) 	80% after you meet the Annual Deductible 100% 100%	60% after you meet the Annual Deductible Not Covered Not Covered

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
- Additional Preventive mammography testing	80% after you meet the Annual Deductible	Not Covered
- Preventive PSA tests	100%	Not Covered
- Preventive colonoscopies	100%	Not Covered
- Sickness and Injury related diagnostic services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
- Sickness and Injury related mammography testing (One per calendar year)	100%	60% after you meet the Annual Deductible
- Additional Sickness and Injury related mammography testing	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient Therapeutic Treatments	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Physician's Office Services - Sickness and Injury No Copayment applies when a Physician charge is not assessed. <ul style="list-style-type: none"> ■ Primary Physician (Copay per visit) ■ Specialist Physician (Copay per visit) 	\$15 per visit \$30 per visit	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Preventive Care Services <ul style="list-style-type: none"> ■ Immunizations ■ Physician Office Services ■ Outpatient Diagnostic Services ■ Breast Pumps 	100% 100% 100% 100%	Not Covered Not Covered Not Covered Not Covered
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Rehabilitation Services - Outpatient (Copay is per visit) See Section 6, Additional Coverage Details, for visit limits	100% after you pay a \$30 Copay	60% after you meet the Annual Deductible
Second Surgical Opinion	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 365 days per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Spinal Treatment (Copay is per visit)	100% after you pay a \$30 Copay	60% after you meet the Annual Deductible
Substance Use Disorder Services <ul style="list-style-type: none"> ■ Hospital - Inpatient Stay ■ Physician's Office Services (Copay is per visit) 	80% after you meet the Annual Deductible 100% after you pay a \$15 Copay	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Transplantation Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Urgent Care Center Services (Copay is per visit)	100% after you pay a \$35 Copay	60% after you meet the Annual Deductible

¹You must notify Care CoordinationSM, as described in Section 4, *Care CoordinationSM* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Care CoordinationSM before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

²These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*, *Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic Lab*, *X-Ray and Diagnostics – Outpatient*, and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Care CoordinationSM before you receive them, and any reduction in Benefits that may apply if you do not call Care CoordinationSM.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Care CoordinationSM. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Ambulance Services - Emergency only

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed.

Cancer Resource Services (CRS)

United Healthcare will arrange for access to certain of its Network providers participating in the Cancer Resource Services Program for the provision of oncology services. You may be referred to Cancer Resource Services by United Healthcare, or you may self refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of Benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and Supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.

In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program.

When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the described in Section 5, *Plan Highlights* under the headings *Physician's Office Services – Sickness and Injury*, *Professional Fees for Surgical and Medical Services*, *Hospital-Inpatient Stay*, *Outpatient Surgery*, *Diagnostic and Therapeutic Services* listed in this section.

Cancer Clinical Trials and related treatment and services are considered a Covered Health Service when such treatment and services are recommended and provided by a Physician in a cancer center. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials

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

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

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

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

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

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
 - certain Category B devices;
 - certain promising interventions for patients with terminal illnesses; and
 - other items and services that meet specified criteria in accordance with our medical and drug policies;

- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list 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). (Includes National Cancer Institute (NCI));
 - Centers for Disease Control and Prevention (CDC);
 - Agency for Healthcare Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);
 - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
 - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
 - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
 - ◆ comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
 - ◆ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before

participants are enrolled in the trial. UnitedHealthcare 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.

Please remember that you must notify Care CoordinationSM as soon as the possibility of participation in a clinical trial arises. If Care CoordinationSM is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Congenital Heart Disease (CHD) Surgeries

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

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

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Care CoordinationSM to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Care CoordinationSM at the toll-free number on your ID card for information about CHD services.

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

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

Dental Services - Accident Only

Dental services when all of the following are true:

- treatment is necessary because of accidental damage;
- dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.";
- the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

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

Dental services for final treatment to repair the damage must be both of the following:

- started within three months of the accident.
- completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Please remember that you should notify Care CoordinationSM as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, Care CoordinationSM can determine whether the service is a Covered Health Service.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that meets each of the following:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable; and
- not of use to a person in the absence of a disease or disability.

If more than one piece of DME can meet your functional needs, Benefits are available only for the most Cost-Effective piece of equipment.

Examples of DME include but are not limited to:

- equipment to assist mobility, such as a standard wheelchair;
- a standard Hospital-type bed;
- oxygen concentrator units and the rental of equipment to administer oxygen;
- delivery pumps for tube feedings;
- braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

UnitedHealthcare provides Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM if the purchase, rental, repair or replacement of DME will cost more than \$1,000. If Care CoordinationSM is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Emergency Health Services - Outpatient

The Plan pays for services that are required to stabilize or initiate treatment in an Emergency. Emergency health services must be received on an outpatient basis at a Hospital or Alternate Facility.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Care CoordinationSM is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

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

Please remember for Non-Network Benefits, you must notify Care CoordinationSM within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. If Care CoordinationSM is not notified, Benefits for the Inpatient Hospital Stay will be reduced to 50% of Eligible Expenses.

Eye Examinations

The Plan pays Benefits for eye examinations received from a health care provider in the provider's office.

Benefits include services for illness or Injury only.

Please note that Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contact lenses.

Home Health Care

Covered Health Services are services received from a Home Health Agency that are both of the following:

- ordered by a Physician; and
- provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.

Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

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

Any combination of Network Benefits and Non-Network Benefits is limited to 50 visits per calendar year. One visit equals four hours of Skilled Care services.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM five business days before receiving services or as soon as reasonably possible. If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

The Plan pays Benefits for hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Any combination of Network Benefits and Non-Network Benefits is limited to 360 days per Covered Person during the entire period you are covered under the Plan.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM five business days before receiving services. If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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

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

Please remember for Non-Network Benefits, you must notify Care CoordinationSM as follows:

- for elective admissions: five business days before admission or as soon as reasonably possible;
- for Emergency admissions (also termed non-elective admissions): within one business day or the same day of admission, or as soon as is reasonably possible.

If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Injections received in a Physician's Office

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

Kidney Resource Services (KRS)

UnitedHealthcare will arrange for access to certain of its Network Providers participating in the Kidney Resource Services Program for End Stage Renal Disease (ESRD) and chronic kidney disease. You may be referred to KRS by UnitedHealthcare, or you may self refer to KRS by calling 888-936-7246 and select the KRS prompt. In order to receive the highest level of Benefits, you must contact KRS prior to obtaining Covered Health Services. The services include Covered Health Services and supplies rendered for the treatment and/or diagnosis relating to ESRD or chronic kidney disease.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

When these services are not performed in a KRS facility, Benefits will be paid the same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services listed in this section.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Maternity Services

Employee and Dependent Spouse Only

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

UnitedHealthcare will pay Benefits for an Inpatient Stay of at least:

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

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

For Dependent Children Only

Pregnancy Benefits for Dependent children are limited to Covered Health Services for Complications of Pregnancy. For a complete definition of Complications of Pregnancy, see Section 14, *Glossary*.

Benefits are payable for Covered Health Services for the treatment of Complications of Pregnancy given to a Dependent child while covered under this Plan.

Benefits for Complications of Pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits for Complications of Pregnancy which result in the delivery of a child are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery; and
- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

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

The following are not considered Complications of Pregnancy:

- false labor;
- occasional spotting;
- rest prescribed by a Physician;
- morning sickness; and
- other conditions that may be connected with a difficult pregnancy but are not a classifiably distinct complication.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If Care CoordinationSM is not notified, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

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

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

Special Mental Health Programs and Services

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

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please refer to Section 4, *Care Coordination*SM for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the *Enhanced Autism Spectrum Disorder* benefit below.

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

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder Benefits

Covered Health Services include enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

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

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

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Care Coordination*SM for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Obesity

The Plan pays for Benefits for hospital, physician, and diagnostic fees associated with morbid obesity if:

- The Participant has a Body Mass Index equal to or greater than 35 and said index has been met for the three years prior to the date of surgery;
- The Participant has at least one co-morbidity that is a direct complication of obesity and that has been previously unsuccessfully treated (this requirement is waived for individuals with a Body Mass Index greater than 40);
- The Participant has, within the 24 months prior to surgery, previously completed one physician supervised weight loss attempt, for a duration no less than six months, that included behavioral therapy, diet changes, and alteration of physical activity when indicated and has been unsuccessful in this effort;
- No previous bariatric surgery for weight reduction.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery

The Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Outpatient Diagnostic Services

The Plan pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

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

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.

Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine

The Plan pays for Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Therapeutic Treatments

The Plan pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Physician's Office Services - Sickness and Injury

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

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

Please Note

Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Preventive Care Services

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

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

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 6, *Plan Highlights*, under *Covered Health Services*.

Benefits are only available if breast pumps are obtained from a DME provider.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;

- Duration of a rental;
- Timing of an acquisition.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Professional Fees for Surgical and Medical Services

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.

Prosthetic Devices

External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital

Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

Please remember that for Non-Network Benefits you must notify Care CoordinationSM five business days before undergoing a Reconstructive Procedure. When you provide notification, Care CoordinationSM can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician (when required by state law). Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

Please note that the Plan will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

Habilitative Services

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

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.

- The initial or continued treatment must be proven and not Experimental or Investigational.

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

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

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

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

Benefits are limited to:

- 20 visits per calendar year for pulmonary rehabilitation therapy; and
- 36 visits per calendar year for cardiac rehabilitation therapy.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Second Surgical Opinion

This is not a required service to obtain Benefits.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

The Plan pays for Covered Health Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds).

Any combination of Network Benefits and Non-Network Benefits is limited to 365 days per calendar year.

Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM as follows:

- for elective admissions: five business days before admission;
- for non-elective admission: within one business day or the same day of admission; and
- for Emergency admissions: as soon as is reasonably possible.

If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Spinal Treatment

Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Coverage is limited to charges incurred.

Spinal Treatment consists of spinal adjustment for acute or chronic subluxation and includes charges for x-rays and other services authorized or recommended by a chiropractor operating within the scope of his license.

Maintenance and preventive care are not covered.

No benefits for Spinal Treatment will be paid under any other section of the Plan.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

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

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

Special Substance Use Disorder Programs and Services

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

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Care Coordination*SM for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

Covered Health Services for organ and tissue transplants when ordered by a Physician. For Network Benefits, transplantation services must be received at a Designated Facility. Transplantation services provided at a non-Designated Facility will be covered as Non-Network Benefits. Benefits are available when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

Notification is required for all transplant services.

The Copayment and Annual Deductible will not apply to Network Benefits when a transplant listed below is received at a Designated Facility. The services described under *Transportation and Lodging* below are Covered Health Services **ONLY** in connection with a transplant received at a Designated Facility.

Examples of transplants for which Benefits are available include but are not limited to:

- bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated Facility.
- heart transplants;
- heart/lung transplants;
- lung transplants;
- kidney transplants;
- kidney/pancreas transplants;
- liver transplants;
- liver/small bowel transplants;
- pancreas transplants; and
- small bowel transplants.

Benefits for cornea transplants that are provided by a Network Physician at a Network Hospital are paid as if the transplant was received at a Designated Facility. Cornea transplants are not required to be performed at a Designated Facility in order for you to receive Network Benefits. Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Please remember for Non-Network Benefits, you must notify United Resource Networks or Care CoordinationSM as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If United Resource Networks or Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Urgent Care Center Services

The Plan pays for Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:

Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

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

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

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and City of Columbia, Missouri are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Assessment

You and your Spouse are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – City of Columbia, Missouri's way of helping you meet your health and wellness goals.

NurseLineSM

NurseLineSM is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that City of Columbia, Missouri has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLineSM gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLineSM is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLineSM.

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLineSM toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLineSM to help answer your health questions.

With NurseLineSM, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

UnitedHealth PremiumSM Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth PremiumSM Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth PremiumSM Program was designed to:

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

For details on the UnitedHealth PremiumSM Program including how to locate a UnitedHealth PremiumSM Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

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

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

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

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Diabetes Prevention and Control

UnitedHealthcare provides two programs that identify, assess, and support members over the age of 18 living with diabetes or pre-diabetes. The program is designed to support members in preventing pre-diabetics from progressing to diabetes and assist members living with diabetes in controlling their condition and from developing complications.

The Diabetes Prevention Program (DPP) is available for members living with pre-diabetes and offers a 16 session lifestyle intervention that addresses diet, activity and behavior

modification. The goal of this program is to slow and/or prevent the development of Type 2 diabetes through lifestyle management and weight loss and is available at local YMCAs.

The Diabetes Control Program (DCP) is available to members living with diabetes and offers face-to-face consultations with trained local pharmacists who will review diabetes history and medication, provide diabetes management education materials and assist individuals living with diabetes with managing their condition. The goal of this program is to reduce the risk of serious health complications through medication management and ongoing monitoring for complications.

Participation is completely voluntary and without extra charge. There are no Copays, Coinsurance or Deductibles that need to be met when services are received as part of the DPP or DCP programs. If you think you may be eligible to participate or would like additional information regarding the programs, please call the DPCA call center directly at (888) 688-4019.

HealtheNotesSM

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;

- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for any of the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure and acupuncture;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. rolfing;
6. other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

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

5. supplies, equipment and similar incidental services and supplies for personal comfort.
Examples include:

- air conditioners;
- air purifiers and filter;
- batteries and battery chargers;
- dehumidifiers;
- humidifiers.
- devices and computers to assist in communication and speech.

Dental

1. dental care, except as described in Section 6, *Additional Coverage Details* under the heading *Dental Services - Accident only*
2. preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums.
Examples include all of the following:
 - extraction, restoration and replacement of teeth;
 - medical or surgical treatments of dental conditions;
 - services to improve dental clinical outcomes.
3. dental implants.
4. dental braces.
5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
 - transplant preparation;
 - initiation of immunosuppressives;
 - the direct treatment of acute traumatic Injury, cancer or cleft palate.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 5, *Additional Coverage Details*.

6. treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a Congenital Anomaly.

Drugs

1. prescription drug products for outpatient use that are filled by a prescription order or refill;
2. self-injectable medications;
3. non-injectable medications given in a Physician's office except as required in an Emergency;

4. over the counter drugs and treatments.

Experimental or Investigational Services or Unproven Services

Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes. Routine foot care services that are not covered include:
 - cutting or removal of corns and calluses;
 - nail trimming or cutting; and
 - debriding (removal of dead skin or underlying tissue);
2. hygienic and preventive maintenance foot care. Examples include the following:
 - cleaning and soaking the feet;
 - applying skin creams in order to maintain skin tone;
 - other services that are performed when there is not a localized illness, Injury or symptom involving the foot;
3. treatment of flat feet;
4. treatment of subluxation of the foot;
5. shoe orthotics.

Medical Supplies and Appliances

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - elastic stockings;
 - ace bandages;
 - gauze and dressings;
 - syringes;

- diabetic test strips;
- 3. orthotic appliances that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.

- 4. cranial banding;
- 5. tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 6, *Additional Coverage Details* under the heading *Durable Medical Equipment*.

Mental Health and Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

- 1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- 2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance-related and addictive disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
 - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
 - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
 - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; and
 - not clinically appropriate for the patient's Mental Illness, substance-related and addictive disorder or condition based on generally accepted standards of medical practice and benchmarks; and
- 3. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- 4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;
- 5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
8. learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
9. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
11. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; and
13. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. megavitamin and nutrition based therapy;
2. Individual and group nutritional counseling. This exclusion does not apply to nutritional counseling services that are billed as Preventive Care Services or to nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - nutritional education is required for a disease in which patient self-management is an important component of treatment; and
 - there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional;
2. enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
3. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:
 - pharmacological regimens, nutritional procedures or treatments;
 - scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
 - skin abrasion procedures performed as a treatment for acne;
2. replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;
3. physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation;
4. weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded;
5. wigs regardless of the reason for the hair loss.

Providers

1. services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself;
2. services performed by a provider with your same legal residence;
3. services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
 - has not been actively involved in your medical care prior to ordering the service; or
 - is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments;
2. surrogate parenting;
3. the reversal of voluntary sterilization;
4. maternity services, including delivery, for Dependent children, except those that have Complications of Pregnancy as defined in Section 14, *Glossary*.

Services Provided under Another Plan

1. health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you;
3. health services while on active military duty.

Transplants

1. health services for organ, multiple organ and tissue transplants, except as described in *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.);
3. health services for transplants involving mechanical or animal organs;
4. any solid organ transplant that is performed as a treatment for cancer.

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services;
2. travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

Vision and Hearing

1. purchase cost of eye glasses, contact lenses or hearing aids;
2. fitting charge for hearing aids, eye glasses or contact lenses;
3. eye exercise or vision therapy;
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery;

5. Routine vision examinations, including refractive examinations;
6. purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

All Other Exclusions

1. health services and supplies that do not meet the definition of a Covered Health Service
- see the definition in Section 14, *Glossary*;

This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;

2. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when;
 - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
 - related to judicial or administrative proceedings or orders;
 - conducted for purposes of medical research; This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*;
 - required to obtain or maintain a license of any type;
3. health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
4. health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends;
5. health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;
6. in the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or the Annual Deductible are waived;
7. charges in excess of Eligible Expenses or in excess of any specified limitation;
8. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature;
9. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea;
10. Surgical treatment of obesity excluding severe morbid obesity: (with a BMI equal to or greater than 35) and the said index has been met for three years prior to the date of the scheduled surgery.

11. Non-surgical treatment of obesity including dietary supplements or supplies used in conjunction with weight loss.
12. growth hormone therapy;
13. sex transformation operations;
14. Custodial Care;
15. domiciliary care;
16. private duty nursing;
17. respite care;
18. rest cures;
19. psychosurgery;
20. treatment of benign gynecomastia (abnormal breast enlargement in males);
21. medical and surgical treatment of excessive sweating (hyperhidrosis);
22. panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to breast reconstruction following a mastectomy as described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;
23. medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;
24. oral appliances for snoring;
25. speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly;
26. any charges for missed appointments, room or facility reservations, completion of claim forms or record processing;
27. any charge for services, supplies or equipment advertised by the provider as free;
28. any charges prohibited by federal anti-kickback or self-referral statutes.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

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

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

Prescription Drug Benefit Claims

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

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay was incorrect.

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

If Your Provider Does Not File Your Claim

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

- Your name and address.
- The patient's name, age and relationship to the Participant.

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

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

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

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

You may not assign your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your Provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to

be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10 *Coordination of Benefits*.

Health Statements

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

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

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

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

Claim Denials and Appeals

If Your Claim is Denied

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

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;

- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

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

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

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

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

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

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

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from City of Columbia, Missouri within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. City of Columbia, Missouri will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by City of Columbia, Missouri, or if City of Columbia, Missouri fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of City of Columbia, Missouri's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

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

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received City of Columbia, Missouri's decision.

An external review request should include all of the following:

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

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

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

Standard External Review

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

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and

- a decision by the IRO.

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

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

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

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

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making City of Columbia, Missouri's determination. The documents include:

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

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

Upon receipt of a Final External Review Decision reversing City of Columbia, Missouri determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral

will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

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

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

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

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

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

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by City of Columbia, Missouri. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72

hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

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

Timing of Appeals Determinations

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

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

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

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

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

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	30 days
■ after receiving the completed claim (if the initial claim is incomplete), within:	30 days

Post-Service Claims	
Type of Claim or Appeal	Timing
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
City of Columbia, Missouri must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

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

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

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

Limitation of Action

You cannot bring any legal action against City of Columbia, Missouri or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against City of Columbia, Missouri or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against City of Columbia, Missouri or the Claims Administrator.

You cannot bring any legal action against City of Columbia, Missouri or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against City of Columbia, Missouri or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you

lose any rights to bring such an action against City of Columbia, Missouri or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

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

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

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

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the Spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the Spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

- 1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
- 2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.
- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare); and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

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. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

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

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary,

wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the Claims Administrator makes payments, with the understanding that the Claims Administrator will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall 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 Sickness or Injury for which a third party is alleged to be responsible.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness 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 received for that Sickness or Injury.

Reimbursement – Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- 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; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its 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 which 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 its agents reasonably request to secure the subrogation and reimbursement claim;
- responding to requests for information about any accident or injuries;
- making court appearances;
- obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
- complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, 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 Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which 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, the Plan's 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 or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive 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, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those

funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation 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, 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 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.
- 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, shall 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 a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

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.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;

- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage;
- Conversion from a group policy to an individual policy; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, City of Columbia, Missouri will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

- the last day of the month your employment with the Company ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month UnitedHealthcare receives written notice from City of Columbia, Missouri to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from City of Columbia, Missouri to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to City of Columbia, Missouri's staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: City of Columbia, Missouri has the right to demand that you pay back Benefits City of Columbia, Missouri paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to City of Columbia, Missouri proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon City of Columbia, Missouri's request, that the child continues to meet these conditions.

The proof might include medical examinations at City of Columbia, Missouri's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- the Total Disability ends; or
- twenty nine months from the date coverage would have ended.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if City of Columbia, Missouri is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Participant;
- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ¹	29 months	29 months	29 months
You die	N/A	36 months	36 months

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
City of Columbia, Missouri files for bankruptcy under Title 11, United States Code. ²	36 months	36 months ³	36 months ³

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

²This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Human Resources with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Conversion from a Group Plan to an Individual Plan

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage, without furnishing evidence of insurability, if:

- you are no longer eligible as a Participant or enrolled Dependent; or
- continuation coverage ends.

This right to conversion coverage is contingent upon the exhaustion of COBRA continuation coverage.

In addition, you may not be eligible for conversion coverage if you are:

- age 65 or older;
- covered under or eligible for coverage under Medicare (title XVIII as amended); or
- covered under or eligible for any group, individual, prepayment, government, or other plan or program which would result in overinsurance if conversion coverage was issued.

You must submit your first application and payment to UnitedHealthcare or its designated insurance company within 31 days after coverage ends under this Plan. UnitedHealthcare or its designated insurance company will issue conversion coverage according to the terms and conditions in effect at the time you apply. Conversion coverage may be substantially different from coverage provided under this Plan. Even though you may be eligible for conversion coverage, UnitedHealthcare does not offer conversion products in certain states.

When a conversion product is not available, the conversion coverage may be provided by a state sponsored risk pool.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Participant's absence from work; or
- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and City of Columbia, Missouri;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and City of Columbia, Missouri

In order to make choices about your health care coverage and treatment, City of Columbia, Missouri believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- City of Columbia, Missouri and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

City of Columbia, Missouri and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. City of Columbia, Missouri and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. City of Columbia, Missouri and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between City of Columbia, Missouri, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not City of Columbia, Missouri's agents or employees, nor are they agents or employees of UnitedHealthcare. City of Columbia, Missouri and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

City of Columbia, Missouri and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, City of Columbia, Missouri and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not City of Columbia, Missouri's employees nor are they employees of UnitedHealthcare. City of Columbia, Missouri and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. City of Columbia, Missouri and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

City of Columbia, Missouri is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

City of Columbia, Missouri and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

City of Columbia, Missouri and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, City of Columbia, Missouri may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that City of Columbia, Missouri does so in any particular case shall not in any way be deemed to require City of Columbia, Missouri to do so in other similar cases.

Information and Records

City of Columbia, Missouri and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. City of Columbia, Missouri and UnitedHealthcare may request additional information from you to decide your claim for Benefits. City of Columbia, Missouri and UnitedHealthcare will keep this information confidential. City of Columbia, Missouri and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish City of Columbia, Missouri and UnitedHealthcare with all information or copies of records relating to the services provided to you. City of Columbia, Missouri and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. City of Columbia, Missouri and UnitedHealthcare agree that such information and records will be considered confidential.

City of Columbia, Missouri and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as City of Columbia, Missouri is required to do by law or regulation. During and after the term of the Plan, City of Columbia, Missouri and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements City of Columbia, Missouri recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

In some cases, City of Columbia, Missouri and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but City of Columbia, Missouri recommends that you discuss participating in such programs with your Physician. These incentives are not

Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

City of Columbia, Missouri and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. City of Columbia, Missouri and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 14 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Columbia, Missouri. The CRS program provides:

- specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Care CoordinationSM – programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – City of Columbia, Missouri.

Complications of Pregnancy – a condition suffered by a Dependent child that requires medical treatment before or after Pregnancy ends.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services or supplies, which UnitedHealthcare determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- included in Sections 5 and 6, *Plan Highlights* and *Additional Coverage Details*;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between a Participant and one other person of the same or opposite sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:
 - they have a single dedicated relationship of at least 6 months duration;
 - they have joint ownership of a residence; or
 - they have at least two of the following:
 - ◆ a joint ownership of an automobile;
 - ◆ a joint checking, bank or investment account;
 - ◆ a joint credit account;
 - ◆ a lease for a residence identifying both partners as tenants; or
 - ◆ a will and/or life insurance policies which designate the other as primary beneficiary.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by Human Resources upon your request.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance use disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – City of Columbia, Missouri.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator and City of Columbia, Missouri make a determination regarding coverage in a particular case, are determined to be any of the following:

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

- Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and City of Columbia, Missouri may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and City of Columbia, Missouri must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Columbia, Missouri. The KRS program provides:

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by City of Columbia, Missouri who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period of time, determined by City of Columbia, Missouri, during which eligible Participants may enroll themselves and their Dependents under the Plan. City of Columbia, Missouri determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The City of Columbia, Missouri Medical Plan.

Plan Administrator – City of Columbia, Missouri or its designee.

Plan Sponsor – City of Columbia, Missouri.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;

- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
 - room and board;
 - evaluation and diagnosis;
 - counseling; and
 - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retired Employee – an Employee who retires while covered under the Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;

- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spinal Treatment – detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Total Disability – a Participant's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when

treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium ProgramSM – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium ProgramSM Physician or facility for certain medical conditions.

To be designated as a UnitedHealth PremiumSM provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium ProgramSM Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Columbia, Missouri may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and City of Columbia, Missouri must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and City of Columbia, Missouri's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order 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 Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Covered Health Services ^{1,2}	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Retail - up to a 31-day supply	100% after you pay a:	
■ tier-1	\$10 Copay	\$10 Copay
■ tier-2	\$25 Copay	\$25 Copay
■ tier-3	\$40 Copay	\$40 Copay
Retail - up to a 90-day supply	100% after you pay a:	
■ tier-1	\$25 Copay	Not Covered
■ tier-2	\$62.50 Copay	Not Covered
■ tier-3	\$100 Copay	Not Covered
Specialty Prescription Drugs - up to 31-day supply		
■ tier-1	\$10 Copay	Not Covered

Covered Health Services ^{1,2}	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Non-Network
■ tier-2	\$25 Copay	Not Covered
■ tier-3	\$40 Copay	Not Covered
Mail order - up to a 90-day supply		
■ tier-1	\$25 Copay	Not Covered
■ tier-2	\$62.50 Copay	Not Covered
■ tier-3	\$100 Copay	Not Covered

¹You, your Physician or your pharmacist must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

²You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drugs as described in this section. Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card) – Network Pharmacy

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

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

Benefit Levels

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

The Plan pays Benefits at different levels for tier-1, tier-2 and 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 can change periodically, generally quarterly but no more than six times per calendar year, 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, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay 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 Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay 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 Copay;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Charge that UnitedHealthcare agreed to pay the Network Pharmacy.

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

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

Retail

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

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day or 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day or 90-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied.

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

Mail Order

The mail order 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 mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. 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 UnitedHealthcare at the toll-free number on your ID card.

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

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

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

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

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drugs*. You may determine whether a drug is a Preventive

Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Designated Pharmacy

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

Specialty Prescription Drugs

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

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy.

Select Designated Pharmacy

You may fill a prescription for a Select Prescription Drug up to two times at any retail Pharmacy. However, after that you will be directed to a Designated Pharmacy. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug from a Designated Pharmacy, non-Network Benefits will apply for that Select Prescription Drug.

For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Please see the Prescription Drug Glossary in this section for the definition of Select Prescription Drug.

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

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

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

Economic factors may include:

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

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

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

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

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

Prescription Drug List (PDL)

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

Notification Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug, in accordance with UnitedHealthcare approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

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

Network Pharmacy Notification

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying the Claims Administrator.

Non-Network Pharmacy Notification

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

If UnitedHealthcare is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. If

UnitedHealthcare is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

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

To determine if a Prescription Drug requires notification, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

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

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

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

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator 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 Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug is assigned.

Special Programs

City of Columbia, Missouri and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

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

Rebates and Other Discounts

UnitedHealthcare and City of Columbia, Missouri may, at times, receive rebates for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays.

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

Coupons, Incentives and Other Communications

UnitedHealthcare may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition.

UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information

on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions* apply also to this section8, . In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drugs, you can access **www.myuhc.com** through the Internet or by calling the telephone number on your ID card for information on which Prescription Drugs are excluded.

Medications that are:

1. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
2. any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;
5. 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 contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3;
6. dispensed outside of the United States, except in an Emergency;

7. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
8. for smoking cessation;
9. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition);
10. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
11. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;
12. certain Prescription Drugs that have not been prescribed by a specialist physician;
13. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
14. prescribed, dispensed or intended for use during an Inpatient Stay;
15. prescribed for appetite suppression, and other weight loss products;
16. prescribed to treat infertility;
17. Prescription Drugs, including new Prescription Drugs or new dosage forms, that UnitedHealthcare and City of Columbia, Missouri determines do not meet the definition of a Covered Health Service;
18. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;
19. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug;
20. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;
21. unit dose packaging of Prescription Drugs;
22. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and City of Columbia, Missouri have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;
23. used for cosmetic purposes;
24. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed; and

25. vitamins, except for the following which require a prescription:

- prenatal vitamins;
- vitamins with fluoride; and
- single entity vitamins.

Glossary - Prescription Drugs

Brand-name - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Designated Pharmacy – a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Claims Administrator as a Network Pharmacy.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Predominant Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. The Claims Administrator calculates the Predominant Reimbursement Rate using its Prescription Drug Charge that applies for that particular Prescription Drug at most Network Pharmacies.

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

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
 - insulin syringes with needles;
 - blood testing strips - glucose;
 - urine testing strips - glucose;
 - ketone testing strips and tablets;
 - lancets and lancet devices;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
 - glucose monitors.

Prescription Drug Charge – the rate the Claims Administrator 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) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

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

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Select Prescription Drug - a Prescription Drug that is generally a tier-3 drug with lower-tiered alternatives used to treat the same condition. For more information, visit myuhc.com or call UnitedHealthcare at the toll-free number on your ID card.

Specialty Prescription Drug - Prescription Drug that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. For more information, visit myuhc.com or call UnitedHealthcare at the toll-free number on your ID card.

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

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is City of Columbia, Missouri, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II – LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- 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 treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:

You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

ParentSteps is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps will collect the provider payment from you online via the ParentSteps website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services (described in the Summary Plan Description Section 5, *Plan Highlights*) when a benefit is available.

What is ParentSteps?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at www.myoptumhealthparentsteps.com or by calling ParentSteps toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see the

specific rates negotiated by ParentSteps with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps member. ParentSteps will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps discounts apply, the provider will enter in your proposed course of treatment. ParentSteps will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps Information

Additional information on the ParentSteps program can be obtained online at www.myoptumhealthparentsteps.com or by calling 1-877-801-3507 (toll-free).

Summary Plan Description

City of Columbia, Missouri Choice Plus \$1,500 Plan

Effective: January 1, 2015
Group Number: 704919



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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Care CoordinationSM and Mental Health/Substance Use Disorder Administrator: (866) 844-4864;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: www.myuhc.com.

City of Columbia, Missouri is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

City of Columbia, Missouri intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. City of Columbia, Missouri is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- City of Columbia, Missouri is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full time employee of the Plan Sponsor, a permanent part-time employee, a non-Medicare eligible retiree, a Spouse of a Medicare eligible retiree under 65 and covered under The Company sponsored Medicare Plan, and a surviving Spouse.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and City of Columbia, Missouri share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of City of Columbia, Missouri's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and City of Columbia, Missouri reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days from your date of hire for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date Human Resources receives notice of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in City of Columbia, Missouri's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under City of Columbia, Missouri's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

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

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

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

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Care CoordinationSM, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, **www.myuhc.com**, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, **www.myuhc.com** has the most current source of Network information. Use **www.myuhc.com** to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto **www.myuhc.com**.

Network providers are independent practitioners and are not employees of City of Columbia, Missouri or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Eligible Expenses

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

Eligible Expenses are the amount the Claims Administrator determines that the Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network

Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
 - ◆ For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
 - ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claims Administrator will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

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

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

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

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum. Copays do not count toward the Annual Deductible. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays, even those for Covered Health Services available in Section 15, <i>Prescription Drugs</i>	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Care Coordination SM	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - CARE COORDINATIONSM

What this section includes:

- An overview of the Care CoordinationSM program; and
- Covered Health Services for which you need to contact Care CoordinationSM.

UnitedHealthcare provides a program called Care CoordinationSM designed to encourage personalized, efficient care for you and your covered Dependents.

Care CoordinationSM nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Care CoordinationSM nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

Care CoordinationSM nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Care CoordinationSM program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Care CoordinationSM nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, a Care CoordinationSM nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care CoordinationSM nurse to confirm that medications, needed equipment, or follow-up services are in place. The Care CoordinationSM nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care CoordinationSM nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care CoordinationSM nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Requirements for Notifying Care CoordinationSM

Network providers are generally responsible for notifying Care CoordinationSM before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Care CoordinationSM.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying Care CoordinationSM before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if Care CoordinationSM is not notified.

The services that require Care CoordinationSM notification are:

- breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature;
- Clinical Trials;
- Congenital Heart Disease services;
- Durable Medical Equipment for items that will cost more than \$1,000 to purchase or rent;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay;
- maternity care that exceeds the delivery timeframes as described in Section 6, *Additional Coverage Details*;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - Autism Spectrum Disorder Services -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Pre-service notification is also required for Benefits provided for Applied Behavioral Analysis (ABA).
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment;

psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; and

- transplantation services.

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

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

Notification is required within one business day of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For notification timeframes, and reductions in Benefits that apply if you do not notify Care CoordinationSM, see Section 6, *Additional Coverage Details*.

Contacting Care Coordination is easy.

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

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Care CoordinationSM before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network	Non-Network
Copays¹		
■ Emergency Health Services	\$200	\$200
■ Physician's Office Services - Primary Physician	\$15	Not Applicable
■ Physician's Office Services - Specialist	\$30	Not Applicable
■ Urgent Care Center Services	\$35	Not Applicable
Annual Deductible²		
■ Individual	\$1,500	\$4,500
■ Family (not to exceed the individual Annual Deductible amount per Covered Person)	\$4,500	\$13,500
Annual Out-of-Pocket Maximum²		
■ Individual	\$4,000	\$12,000
■ Family (not to exceed the individual Annual Out-of-Pocket Maximum amount per Covered Person)	\$12,000	\$36,000
Lifetime Maximum Benefit³ There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

¹In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services, a Copay does not apply when you visit a non-Network provider.

²Copays apply toward the Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

³Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:

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

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Ambulance Services - Emergency Only	<i>Ground Transportation</i> 80% after you meet the Annual Deductible <i>Air Transportation</i> 80% after you meet the Annual Deductible	<i>Ground Transportation</i> 80% after you meet the Annual Deductible <i>Air Transportation</i> 80% after you meet the Annual Deductible
Cancer Resource Services (CRS)² ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	Not Covered
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Durable Medical Equipment (DME)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Emergency Health Services If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a \$200 Copay	
Home Health Care Up to 50 visits per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care Up to 360 days per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Injections received in a Physician's Office	80% per injection	60% per injection after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	80% after you meet the Annual Deductible	Not Covered
Maternity Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Mental Health Services <ul style="list-style-type: none"> ■ Hospital - Inpatient Stay ■ Physician's Office Services (Copay is per visit) 	80% after you meet the Annual Deductible 100% after you pay a \$15 Copay	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services <ul style="list-style-type: none"> ■ Hospital - Inpatient Stay ■ Physician's Office Services (Copay is per visit) 	80% after you meet the Annual Deductible 100% after you pay a \$15 Copay	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Obesity	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Outpatient Surgery, Diagnostic and Therapeutic Services <ul style="list-style-type: none"> ■ Outpatient Surgery ■ Outpatient Diagnostic Services <ul style="list-style-type: none"> - Lab and radiology/X-ray 	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
<ul style="list-style-type: none"> - Mammography testing (One per calendar year) - Additional mammography testing ■ Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine ■ Outpatient Therapeutic Treatments 	<p>100%</p> <p>80% after you meet the Annual Deductible</p> <p>80% after you meet the Annual Deductible</p> <p>80% after you meet the Annual Deductible</p>	<p>60% after you meet the Annual Deductible</p> <p>60% after you meet the Annual Deductible</p> <p>60% after you meet the Annual Deductible</p> <p>60% after you meet the Annual Deductible</p>
<p>Physician's Office Services - Sickness and Injury</p> <p>No Copayment applies when a Physician charge is not assessed.</p> <ul style="list-style-type: none"> ■ Primary Physician (Copay per visit) ■ Specialist Physician (Copay per visit) 	<p>\$15 per visit</p> <p>\$30 per visit</p>	<p>60% after you meet the Annual Deductible</p> <p>60% after you meet the Annual Deductible</p>
<p>Preventive Care Services</p> <ul style="list-style-type: none"> ■ Immunizations ■ Physician Office Services ■ Outpatient Diagnostic Services ■ Breast Pumps 	<p>100%</p> <p>100%</p> <p>100%</p> <p>100%</p>	<p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p> <p>Not Covered</p>
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient (Copay is per visit) See Section 6, Additional Coverage Details, for visit limits	100% after you pay a \$30 Copay	60% after you meet the Annual Deductible
Second Surgical Opinion	Same as Physician's Office Services - Sickness and Injury	Same as Physician's Office Services - Sickness and Injury
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 365 days per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Spinal Treatment (Copay is per visit)	100% after you pay a \$30 Copay	60% after you meet the Annual Deductible
Substance Use Disorder Services <ul style="list-style-type: none"> ■ Hospital - Inpatient Stay ■ Physician's Office Services (Copay is per visit) 	80% after you meet the Annual Deductible 100% after you pay a \$15 Copay	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Transplantation Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Urgent Care Center Services (Copay is per visit)	100% after you pay a \$35 Copay	60% after you meet the Annual Deductible

¹You must notify Care CoordinationSM, as described in Section 4, *Care CoordinationSM* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Care CoordinationSM before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

²These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*, *Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic Lab*, *X-Ray and Diagnostics – Outpatient*, and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Care CoordinationSM before you receive them, and any reduction in Benefits that may apply if you do not call Care CoordinationSM.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Care CoordinationSM. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Ambulance Services - Emergency only

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed.

Cancer Resource Services (CRS)

United Healthcare will arrange for access to certain of its Network providers participating in the Cancer Resource Services Program for the provision of oncology services. You may be referred to Cancer Resource Services by United Healthcare, or you may self refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of Benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and Supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.

In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program.

When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the described in Section 5, *Plan Highlights* under the headings *Physician's Office Services – Sickness and Injury*, *Professional Fees for Surgical and Medical Services*, *Hospital-Inpatient Stay*, *Outpatient Surgery*, *Diagnostic and Therapeutic Services* listed in this section.

Cancer Clinical Trials and related treatment and services are considered a Covered Health Service when such treatment and services are recommended and provided by a Physician in a cancer center. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials

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

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

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

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

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

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
 - certain Category B devices;
 - certain promising interventions for patients with terminal illnesses; and
 - other items and services that meet specified criteria in accordance with our medical and drug policies;

- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list 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). (Includes National Cancer Institute (NCI));
 - Centers for Disease Control and Prevention (CDC);
 - Agency for Healthcare Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);
 - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
 - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
 - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
 - ◆ comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
 - ◆ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before

participants are enrolled in the trial. UnitedHealthcare 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.

Please remember that you must notify Care CoordinationSM as soon as the possibility of participation in a clinical trial arises. If Care CoordinationSM is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Congenital Heart Disease (CHD) Surgeries

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

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

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Care CoordinationSM to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Care CoordinationSM at the toll-free number on your ID card for information about CHD services.

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

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

Dental Services - Accident Only

Dental services when all of the following are true:

- treatment is necessary because of accidental damage;
- dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.";
- the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

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

Dental services for final treatment to repair the damage must be both of the following:

- started within three months of the accident.
- completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Please remember that you should notify Care CoordinationSM as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, Care CoordinationSM can determine whether the service is a Covered Health Service.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that meets each of the following:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable; and
- not of use to a person in the absence of a disease or disability.

If more than one piece of DME can meet your functional needs, Benefits are available only for the most Cost-Effective piece of equipment.

Examples of DME include but are not limited to:

- equipment to assist mobility, such as a standard wheelchair;
- a standard Hospital-type bed;
- oxygen concentrator units and the rental of equipment to administer oxygen;
- delivery pumps for tube feedings;
- braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

UnitedHealthcare provides Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM if the purchase, rental, repair or replacement of DME will cost more than \$1,000. If Care CoordinationSM is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Emergency Health Services - Outpatient

The Plan pays for services that are required to stabilize or initiate treatment in an Emergency. Emergency health services must be received on an outpatient basis at a Hospital or Alternate Facility.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Care CoordinationSM is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

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

Please remember for Non-Network Benefits, you must notify Care CoordinationSM within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. If Care CoordinationSM is not notified, Benefits for the Inpatient Hospital Stay will be reduced to 50% of Eligible Expenses.

Home Health Care

Covered Health Services are services received from a Home Health Agency that are both of the following:

- ordered by a Physician; and
- provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.

Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

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

Any combination of Network Benefits and Non-Network Benefits is limited to 50 visits per calendar year. One visit equals four hours of Skilled Care services.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM five business days before receiving services or as soon as reasonably possible. If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

The Plan pays Benefits for hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Any combination of Network Benefits and Non-Network Benefits is limited to 360 days per Covered Person during the entire period you are covered under the Plan.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM five business days before receiving services. If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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

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

Please remember for Non-Network Benefits, you must notify Care CoordinationSM as follows:

- for elective admissions: five business days before admission or as soon as reasonably possible;
- for Emergency admissions (also termed non-elective admissions): within one business day or the same day of admission, or as soon as is reasonably possible.

If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Injections received in a Physician's Office

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

Kidney Resource Services (KRS)

UnitedHealthcare will arrange for access to certain of its Network Providers participating in the Kidney Resource Services Program for End Stage Renal Disease (ESRD) and chronic kidney disease. You may be referred to KRS by UnitedHealthcare, or you may self refer to KRS by calling 888-936-7246 and select the KRS prompt. In order to receive the highest level of Benefits, you must contact KRS prior to obtaining Covered Health Services. The services include Covered Health Services and supplies rendered for the treatment and/or diagnosis relating to ESRD or chronic kidney disease.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

When these services are not performed in a KRS facility, Benefits will be paid the same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services listed in this section.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Maternity Services

Employee and Dependent Spouse Only

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

UnitedHealthcare will pay Benefits for an Inpatient Stay of at least:

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

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

For Dependent Children Only

Pregnancy Benefits for Dependent children are limited to Covered Health Services for Complications of Pregnancy. For a complete definition of Complications of Pregnancy, see Section 14, *Glossary*.

Benefits are payable for Covered Health Services for the treatment of Complications of Pregnancy given to a Dependent child while covered under this Plan.

Benefits for Complications of Pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits for Complications of Pregnancy which result in the delivery of a child are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery; and

- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

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

The following are not considered Complications of Pregnancy:

- false labor;
- occasional spotting;
- rest prescribed by a Physician;
- morning sickness; and
- other conditions that may be connected with a difficult pregnancy but are not a classifiably distinct complication.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If Care CoordinationSM is not notified, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

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

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

Special Mental Health Programs and Services

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

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please refer to Section 4, *Care Coordination*SM for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the *Enhanced Autism Spectrum Disorder* benefit below.

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

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;

- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder Benefits

Covered Health Services include enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

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

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

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Care CoordinationSM* for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Obesity

The Plan pays for Benefits for hospital, physician, and diagnostic fees associated with morbid obesity if:

- The Participant has a Body Mass Index equal to or greater than 35 and said index has been met for the three years prior to the date of surgery;
- The Participant has at least one co-morbidity that is a direct complication of obesity and that has been previously unsuccessfully treated (this requirement is waived for individuals with a Body Mass Index greater than 40);
- The Participant has, within the 24 months prior to surgery, previously completed one physician supervised weight loss attempt, for a duration no less than six months, that included behavioral therapy, diet changes, and alteration of physical activity when indicated and has been unsuccessful in this effort;

- No previous bariatric surgery for weight reduction.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery

The Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Outpatient Diagnostic Services

The Plan pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

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

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.

Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine

The Plan pays for Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Therapeutic Treatments

The Plan pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Physician's Office Services - Sickness and Injury

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

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

Please Note

Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Preventive Care Services

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

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 6, *Plan Highlights*, under *Covered Health Services*.

Benefits are only available if breast pumps are obtained from a DME provider.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

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

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Professional Fees for Surgical and Medical Services

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.

Prosthetic Devices

External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function.

Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

Please remember that for Non-Network Benefits you must notify Care CoordinationSM five business days before undergoing a Reconstructive Procedure. When you provide notification, Care CoordinationSM can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician (when required by state law). Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

Please note that the Plan will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

Habilitative Services

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

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

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

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable

progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

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

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

Benefits are limited to:

- 20 visits per calendar year for pulmonary rehabilitation therapy; and
- 36 visits per calendar year for cardiac rehabilitation therapy.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Second Surgical Opinion

This is not a required service to obtain Benefits.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

The Plan pays for Covered Health Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds).

Any combination of Network Benefits and Non-Network Benefits is limited to 365 days per calendar year.

Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM as follows:

- for elective admissions: five business days before admission;
- for non-elective admission: within one business day or the same day of admission; and
- for Emergency admissions: as soon as is reasonably possible.

If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Spinal Treatment

Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Coverage is limited to charges incurred.

Spinal Treatment consists of spinal adjustment for acute or chronic subluxation and includes charges for x-rays and other services authorized or recommended by a chiropractor operating within the scope of his license.

Maintenance and preventive care are not covered.

No benefits for Spinal Treatment will be paid under any other section of the Plan.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and

■ Intensive Outpatient Treatment.

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

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

Special Substance Use Disorder Programs and Services

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

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Care Coordination*SM for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

Covered Health Services for organ and tissue transplants when ordered by a Physician. For Network Benefits, transplantation services must be received at a Designated Facility. Transplantation services provided at a non-Designated Facility will be covered as Non-Network Benefits. Benefits are available when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

Notification is required for all transplant services.

The Copayment and Annual Deductible will not apply to Network Benefits when a transplant listed below is received at a Designated Facility. The services described under *Transportation and Lodging* below are Covered Health Services **ONLY** in connection with a transplant received at a Designated Facility.

Examples of transplants for which Benefits are available include but are not limited to:

- bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated Facility.
- heart transplants;
- heart/lung transplants;
- lung transplants;
- kidney transplants;
- kidney/pancreas transplants;
- liver transplants;
- liver/small bowel transplants;
- pancreas transplants; and
- small bowel transplants.

Benefits for cornea transplants that are provided by a Network Physician at a Network Hospital are paid as if the transplant was received at a Designated Facility. Cornea transplants are not required to be performed at a Designated Facility in order for you to receive Network Benefits. Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Please remember for Non-Network Benefits, you must notify United Resource Networks or Care CoordinationSM as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If United Resource Networks or Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Urgent Care Center Services

The Plan pays for Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:

Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

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

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

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and City of Columbia, Missouri are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Assessment

You and your Spouse are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – City of Columbia, Missouri's way of helping you meet your health and wellness goals.

NurseLineSM

NurseLineSM is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that City of Columbia, Missouri has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLineSM gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLineSM is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLineSM.

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLineSM toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLineSM to help answer your health questions.

With NurseLineSM, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

UnitedHealth PremiumSM Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth PremiumSM Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth PremiumSM Program was designed to:

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

For details on the UnitedHealth PremiumSM Program including how to locate a UnitedHealth PremiumSM Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

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

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

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

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Diabetes Prevention and Control

UnitedHealthcare provides two programs that identify, assess, and support members over the age of 18 living with diabetes or pre-diabetes. The program is designed to support members in preventing pre-diabetics from progressing to diabetes and assist members living with diabetes in controlling their condition and from developing complications.

The Diabetes Prevention Program (DPP) is available for members living with pre-diabetes and offers a 16 session lifestyle intervention that addresses diet, activity and behavior

modification. The goal of this program is to slow and/or prevent the development of Type 2 diabetes through lifestyle management and weight loss and is available at local YMCAs.

The Diabetes Control Program (DCP) is available to members living with diabetes and offers face-to-face consultations with trained local pharmacists who will review diabetes history and medication, provide diabetes management education materials and assist individuals living with diabetes with managing their condition. The goal of this program is to reduce the risk of serious health complications through medication management and ongoing monitoring for complications.

Participation is completely voluntary and without extra charge. There are no Copays, Coinsurance or Deductibles that need to be met when services are received as part of the DPP or DCP programs. If you think you may be eligible to participate or would like additional information regarding the programs, please call the DPCA call center directly at (888) 688-4019.

HealtheNotesSM

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;

- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for any of the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure and acupuncture;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. rolfing;
6. other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

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

5. supplies, equipment and similar incidental services and supplies for personal comfort.
Examples include:

- air conditioners;
- air purifiers and filter;
- batteries and battery chargers;
- dehumidifiers;
- humidifiers.
- devices and computers to assist in communication and speech.

Dental

1. dental care, except as described in Section 6, *Additional Coverage Details* under the heading *Dental Services - Accident only*

2. preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums.
Examples include all of the following:

- extraction, restoration and replacement of teeth;
- medical or surgical treatments of dental conditions;
- services to improve dental clinical outcomes.

3. dental implants.

4. dental braces.

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:

- transplant preparation;
- initiation of immunosuppressives;
- the direct treatment of acute traumatic Injury, cancer or cleft palate.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 5, *Additional Coverage Details*.

6. treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a Congenital Anomaly.

Drugs

1. prescription drug products for outpatient use that are filled by a prescription order or refill;
2. self-injectable medications;
3. non-injectable medications given in a Physician's office except as required in an Emergency;

4. over the counter drugs and treatments.

Experimental or Investigational Services or Unproven Services

Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes. Routine foot care services that are not covered include:
 - cutting or removal of corns and calluses;
 - nail trimming or cutting; and
 - debriding (removal of dead skin or underlying tissue);
2. hygienic and preventive maintenance foot care. Examples include the following:
 - cleaning and soaking the feet;
 - applying skin creams in order to maintain skin tone;
 - other services that are performed when there is not a localized illness, Injury or symptom involving the foot;
3. treatment of flat feet;
4. treatment of subluxation of the foot;
5. shoe orthotics.

Medical Supplies and Appliances

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - elastic stockings;
 - ace bandages;
 - gauze and dressings;
 - syringes;

- diabetic test strips;
- 3. orthotic appliances that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.

- 4. cranial banding;
- 5. tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 6, *Additional Coverage Details* under the heading *Durable Medical Equipment*.

Mental Health and Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

- 1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- 2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance-related and addictive disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
 - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
 - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
 - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; and
 - not clinically appropriate for the patient's Mental Illness, substance-related and addictive disorder or condition based on generally accepted standards of medical practice and benchmarks; and
- 3. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- 4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;
- 5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
8. learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
9. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
11. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; and
13. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. megavitamin and nutrition based therapy;
2. Individual and group nutritional counseling. This exclusion does not apply to nutritional counseling services that are billed as Preventive Care Services or to nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - nutritional education is required for a disease in which patient self-management is an important component of treatment; and
 - there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional;
2. enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
3. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:
 - pharmacological regimens, nutritional procedures or treatments;
 - scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
 - skin abrasion procedures performed as a treatment for acne;
2. replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;
3. physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation;
4. weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded;
5. wigs regardless of the reason for the hair loss.

Providers

1. services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself;
2. services performed by a provider with your same legal residence;
3. services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
 - has not been actively involved in your medical care prior to ordering the service; or
 - is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments;
2. surrogate parenting;
3. the reversal of voluntary sterilization;
4. maternity services, including delivery, for Dependent children, except those that have Complications of Pregnancy as defined in Section 14, *Glossary*.

Services Provided under Another Plan

1. health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you;
3. health services while on active military duty.

Transplants

1. health services for organ, multiple organ and tissue transplants, except as described in *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.);
3. health services for transplants involving mechanical or animal organs;
4. any solid organ transplant that is performed as a treatment for cancer.

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services;
2. travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

Vision and Hearing

1. purchase cost of eye glasses, contact lenses or hearing aids;
2. fitting charge for hearing aids, eye glasses or contact lenses;
3. eye exercise or vision therapy;
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery;

5. Routine vision examinations, including refractive examinations;
6. purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

All Other Exclusions

1. health services and supplies that do not meet the definition of a Covered Health Service
- see the definition in Section 14, *Glossary*;

This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;

2. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when;
 - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
 - related to judicial or administrative proceedings or orders;
 - conducted for purposes of medical research; This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*;
 - required to obtain or maintain a license of any type;
3. health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
4. health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends;
5. health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;
6. in the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or the Annual Deductible are waived;
7. charges in excess of Eligible Expenses or in excess of any specified limitation;
8. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature;
9. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea;
10. Surgical treatment of obesity excluding severe morbid obesity: (with a BMI equal to or greater than 35) and the said index has been met for three years prior to the date of the scheduled surgery.

11. Non-surgical treatment of obesity including dietary supplements or supplies used in conjunction with weight loss.
12. growth hormone therapy;
13. sex transformation operations;
14. Custodial Care;
15. domiciliary care;
16. private duty nursing;
17. respite care;
18. rest cures;
19. psychosurgery;
20. treatment of benign gynecomastia (abnormal breast enlargement in males);
21. medical and surgical treatment of excessive sweating (hyperhidrosis);
22. panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to breast reconstruction following a mastectomy as described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;
23. medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;
24. oral appliances for snoring;
25. speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly;
26. any charges for missed appointments, room or facility reservations, completion of claim forms or record processing;
27. any charge for services, supplies or equipment advertised by the provider as free;
28. any charges prohibited by federal anti-kickback or self-referral statutes.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

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

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

Prescription Drug Benefit Claims

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

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay was incorrect.

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

If Your Provider Does Not File Your Claim

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

- Your name and address.
- The patient's name, age and relationship to the Participant.

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

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

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

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

You may not assign your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your Provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to

be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10 *Coordination of Benefits*.

Health Statements

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

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

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

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

Claim Denials and Appeals

If Your Claim is Denied

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

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;

- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

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

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

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

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

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

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

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from City of Columbia, Missouri within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. City of Columbia, Missouri will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by City of Columbia, Missouri, or if City of Columbia, Missouri fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of City of Columbia, Missouri's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

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

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received City of Columbia, Missouri's decision.

An external review request should include all of the following:

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

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

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

Standard External Review

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

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and

- a decision by the IRO.

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

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

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

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

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making City of Columbia, Missouri's determination. The documents include:

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

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

Upon receipt of a Final External Review Decision reversing City of Columbia, Missouri determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral

will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

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

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

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

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

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

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by City of Columbia, Missouri. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72

hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

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

Timing of Appeals Determinations

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

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

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

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

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

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	30 days
■ after receiving the completed claim (if the initial claim is incomplete), within:	30 days

Post-Service Claims	
Type of Claim or Appeal	Timing
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
City of Columbia, Missouri must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

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

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

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

Limitation of Action

You cannot bring any legal action against City of Columbia, Missouri or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against City of Columbia, Missouri or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against City of Columbia, Missouri or the Claims Administrator.

You cannot bring any legal action against City of Columbia, Missouri or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against City of Columbia, Missouri or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you

lose any rights to bring such an action against City of Columbia, Missouri or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

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

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

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

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the Spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the Spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

- 1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
- 2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.
- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare); and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

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. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

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

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary,

wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the Claims Administrator makes payments, with the understanding that the Claims Administrator will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall 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 Sickness or Injury for which a third party is alleged to be responsible.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness 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 received for that Sickness or Injury.

Reimbursement – Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- 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; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its 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 which 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 its agents reasonably request to secure the subrogation and reimbursement claim;
- responding to requests for information about any accident or injuries;
- making court appearances;
- obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
- complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, 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 Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which 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, the Plan's 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 or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive 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, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those

funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation 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, 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 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.
- 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, shall 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 a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

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.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;

- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage;
- Conversion from a group policy to an individual policy; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, City of Columbia, Missouri will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

- the last day of the month your employment with the Company ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month UnitedHealthcare receives written notice from City of Columbia, Missouri to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from City of Columbia, Missouri to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to City of Columbia, Missouri's staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: City of Columbia, Missouri has the right to demand that you pay back Benefits City of Columbia, Missouri paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to City of Columbia, Missouri proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon City of Columbia, Missouri's request, that the child continues to meet these conditions.

The proof might include medical examinations at City of Columbia, Missouri's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- the Total Disability ends; or
- twenty nine months from the date coverage would have ended.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if City of Columbia, Missouri is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Participant;
- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ¹	29 months	29 months	29 months
You die	N/A	36 months	36 months

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
City of Columbia, Missouri files for bankruptcy under Title 11, United States Code. ²	36 months	36 months ³	36 months ³

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

²This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Human Resources with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Conversion from a Group Plan to an Individual Plan

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage, without furnishing evidence of insurability, if:

- you are no longer eligible as a Participant or enrolled Dependent; or
- continuation coverage ends.

This right to conversion coverage is contingent upon the exhaustion of COBRA continuation coverage.

In addition, you may not be eligible for conversion coverage if you are:

- age 65 or older;
- covered under or eligible for coverage under Medicare (title XVIII as amended); or
- covered under or eligible for any group, individual, prepayment, government, or other plan or program which would result in overinsurance if conversion coverage was issued.

You must submit your first application and payment to UnitedHealthcare or its designated insurance company within 31 days after coverage ends under this Plan. UnitedHealthcare or its designated insurance company will issue conversion coverage according to the terms and conditions in effect at the time you apply. Conversion coverage may be substantially different from coverage provided under this Plan. Even though you may be eligible for conversion coverage, UnitedHealthcare does not offer conversion products in certain states.

When a conversion product is not available, the conversion coverage may be provided by a state sponsored risk pool.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Participant's absence from work; or
- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and City of Columbia, Missouri;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and City of Columbia, Missouri

In order to make choices about your health care coverage and treatment, City of Columbia, Missouri believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- City of Columbia, Missouri and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

City of Columbia, Missouri and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. City of Columbia, Missouri and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. City of Columbia, Missouri and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between City of Columbia, Missouri, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not City of Columbia, Missouri's agents or employees, nor are they agents or employees of UnitedHealthcare. City of Columbia, Missouri and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

City of Columbia, Missouri and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, City of Columbia, Missouri and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not City of Columbia, Missouri's employees nor are they employees of UnitedHealthcare. City of Columbia, Missouri and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. City of Columbia, Missouri and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

City of Columbia, Missouri is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

City of Columbia, Missouri and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

City of Columbia, Missouri and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, City of Columbia, Missouri may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that City of Columbia, Missouri does so in any particular case shall not in any way be deemed to require City of Columbia, Missouri to do so in other similar cases.

Information and Records

City of Columbia, Missouri and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. City of Columbia, Missouri and UnitedHealthcare may request additional information from you to decide your claim for Benefits. City of Columbia, Missouri and UnitedHealthcare will keep this information confidential. City of Columbia, Missouri and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish City of Columbia, Missouri and UnitedHealthcare with all information or copies of records relating to the services provided to you. City of Columbia, Missouri and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. City of Columbia, Missouri and UnitedHealthcare agree that such information and records will be considered confidential.

City of Columbia, Missouri and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as City of Columbia, Missouri is required to do by law or regulation. During and after the term of the Plan, City of Columbia, Missouri and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements City of Columbia, Missouri recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

In some cases, City of Columbia, Missouri and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but City of Columbia, Missouri recommends that you discuss participating in such programs with your Physician. These incentives are not

Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

City of Columbia, Missouri and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. City of Columbia, Missouri and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 14 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Columbia, Missouri. The CRS program provides:

- specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Care CoordinationSM – programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – City of Columbia, Missouri.

Complications of Pregnancy – a condition suffered by a Dependent child that requires medical treatment before or after Pregnancy ends.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services or supplies, which UnitedHealthcare determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- included in Sections 5 and 6, *Plan Highlights* and *Additional Coverage Details*;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.myuhc.com** or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between a Participant and one other person of the same or opposite sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:
 - they have a single dedicated relationship of at least 6 months duration;
 - they have joint ownership of a residence; or
 - they have at least two of the following:
 - ◆ a joint ownership of an automobile;
 - ◆ a joint checking, bank or investment account;
 - ◆ a joint credit account;
 - ◆ a lease for a residence identifying both partners as tenants; or
 - ◆ a will and/or life insurance policies which designate the other as primary beneficiary.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by Human Resources upon your request.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and

- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance use disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – City of Columbia, Missouri.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator and City of Columbia, Missouri make a determination regarding coverage in a particular case, are determined to be any of the following:

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

- Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and City of Columbia, Missouri may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and City of Columbia, Missouri must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Columbia, Missouri. The KRS program provides:

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by City of Columbia, Missouri who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period of time, determined by City of Columbia, Missouri, during which eligible Participants may enroll themselves and their Dependents under the Plan. City of Columbia, Missouri determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The City of Columbia, Missouri Medical Plan.

Plan Administrator – City of Columbia, Missouri or its designee.

Plan Sponsor – City of Columbia, Missouri.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;

- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
 - room and board;
 - evaluation and diagnosis;
 - counseling; and
 - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retired Employee – an Employee who retires while covered under the Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;

- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spinal Treatment – detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Total Disability – a Participant's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when

treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium ProgramSM – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium ProgramSM Physician or facility for certain medical conditions.

To be designated as a UnitedHealth PremiumSM provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium ProgramSM Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Columbia, Missouri may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and City of Columbia, Missouri must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and City of Columbia, Missouri's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order 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 Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Covered Health Services ^{1,2}	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Retail - up to a 31-day supply	100% after you pay a:	
■ tier-1	\$10 Copay	\$10 Copay
■ tier-2	\$25 Copay	\$25 Copay
■ tier-3	\$40 Copay	\$40 Copay
Retail - up to a 90-day supply	100% after you pay a:	
■ tier-1	\$25 Copay	Not Covered
■ tier-2	\$62.50 Copay	Not Covered
■ tier-3	\$100 Copay	Not Covered
Specialty Prescription Drugs - up to 31-day supply		
■ tier-1	\$10 Copay	Not Covered

Covered Health Services ^{1,2}	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Non-Network
■ tier-2	\$25 Copay	Not Covered
■ tier-3	\$40 Copay	Not Covered
Mail order - up to a 90-day supply		
■ tier-1	\$25 Copay	Not Covered
■ tier-2	\$62.50 Copay	Not Covered
■ tier-3	\$100 Copay	Not Covered

¹You, your Physician or your pharmacist must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

²You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drugs as described in this section. Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card) – Network Pharmacy

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

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

Benefit Levels

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

The Plan pays Benefits at different levels for tier-1, tier-2 and 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 can change periodically, generally quarterly but no more than six times per calendar year, 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, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay 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 Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay 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 Copay;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Charge that UnitedHealthcare agreed to pay the Network Pharmacy.

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

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

Retail

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

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day or 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day or 90-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied.

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

Mail Order

The mail order 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 mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. 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 UnitedHealthcare at the toll-free number on your ID card.

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

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

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

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

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drugs*. You may determine whether a drug is a Preventive

Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Designated Pharmacy

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

Specialty Prescription Drugs

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

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy.

Select Designated Pharmacy

You may fill a prescription for a Select Prescription Drug up to two times at any retail Pharmacy. However, after that you will be directed to a Designated Pharmacy. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug from a Designated Pharmacy, non-Network Benefits will apply for that Select Prescription Drug.

For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Please see the Prescription Drug Glossary in this section for the definition of Select Prescription Drug.

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

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

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

Economic factors may include:

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

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

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

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

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

Prescription Drug List (PDL)

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

Notification Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug, in accordance with UnitedHealthcare approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

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

Network Pharmacy Notification

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying the Claims Administrator.

Non-Network Pharmacy Notification

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

If UnitedHealthcare is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. If

UnitedHealthcare is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

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

To determine if a Prescription Drug requires notification, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

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

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

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

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator 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 Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug is assigned.

Special Programs

City of Columbia, Missouri and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

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

Rebates and Other Discounts

UnitedHealthcare and City of Columbia, Missouri may, at times, receive rebates for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays.

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

Coupons, Incentives and Other Communications

UnitedHealthcare may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition.

UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information

on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions* apply also to this section8, . In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drugs, you can access **www.myuhc.com** through the Internet or by calling the telephone number on your ID card for information on which Prescription Drugs are excluded.

Medications that are:

1. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
2. any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;
5. 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 contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3;
6. dispensed outside of the United States, except in an Emergency;

7. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
8. for smoking cessation;
9. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition);
10. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
11. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;
12. certain Prescription Drugs that have not been prescribed by a specialist physician;
13. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
14. prescribed, dispensed or intended for use during an Inpatient Stay;
15. prescribed for appetite suppression, and other weight loss products;
16. prescribed to treat infertility;
17. Prescription Drugs, including new Prescription Drugs or new dosage forms, that UnitedHealthcare and City of Columbia, Missouri determines do not meet the definition of a Covered Health Service;
18. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;
19. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug;
20. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;
21. unit dose packaging of Prescription Drugs;
22. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and City of Columbia, Missouri have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;
23. used for cosmetic purposes;
24. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed; and

25. vitamins, except for the following which require a prescription:

- prenatal vitamins;
- vitamins with fluoride; and
- single entity vitamins.

Glossary - Prescription Drugs

Brand-name - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Designated Pharmacy – a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Claims Administrator as a Network Pharmacy.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Predominant Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. The Claims Administrator calculates the Predominant Reimbursement Rate using its Prescription Drug Charge that applies for that particular Prescription Drug at most Network Pharmacies.

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

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
 - insulin syringes with needles;
 - blood testing strips - glucose;
 - urine testing strips - glucose;
 - ketone testing strips and tablets;
 - lancets and lancet devices;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
 - glucose monitors.

Prescription Drug Charge – the rate the Claims Administrator 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) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

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

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Select Prescription Drug - a Prescription Drug that is generally a tier-3 drug with lower-tiered alternatives used to treat the same condition. For more information, visit myuhc.com or call UnitedHealthcare at the toll-free number on your ID card.

Specialty Prescription Drug - Prescription Drug that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. For more information, visit myuhc.com or call UnitedHealthcare at the toll-free number on your ID card.

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

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is City of Columbia, Missouri, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II – LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- 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 treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:

You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

ParentSteps is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps will collect the provider payment from you online via the ParentSteps website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services (described in the Summary Plan Description Section 5, *Plan Highlights*) when a benefit is available.

What is ParentSteps?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at www.myoptumhealthparentsteps.com or by calling ParentSteps toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see the

specific rates negotiated by ParentSteps with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps member. ParentSteps will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps discounts apply, the provider will enter in your proposed course of treatment. ParentSteps will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps Information

Additional information on the ParentSteps program can be obtained online at www.myoptumhealthparentsteps.com or by calling 1-877-801-3507 (toll-free).

Summary Plan Description

City of Columbia, Missouri
Choice Plus \$2,500 High Deductible Health Plan

Effective: January 1, 2015
Group Number: 704919



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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Care CoordinationSM and Mental Health/Substance Use Disorder Administrator: (866) 844-4864;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: www.myuhc.com.

City of Columbia, Missouri is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

City of Columbia, Missouri intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. City of Columbia, Missouri is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- City of Columbia, Missouri is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full time employee of the Plan Sponsor, a permanent part-time employee, a non-Medicare eligible retiree, a Spouse of a Medicare eligible retiree under 65 and covered under The Company sponsored Medicare Plan, and a surviving Spouse.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
- an unmarried child age 26 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. In addition, if you and your Spouse are both covered under the Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and City of Columbia, Missouri share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of City of Columbia, Missouri's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and City of Columbia, Missouri reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days from your date of hire for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following January 1.

Important

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following your date of hire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date Human Resources receives notice of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 26 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in City of Columbia, Missouri's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under City of Columbia, Missouri's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

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

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

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

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Care CoordinationSM, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of City of Columbia, Missouri or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Eligible Expenses

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

Eligible Expenses are the amount the Claims Administrator determines that the Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network

Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount the Claims Administrator will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
 - ◆ For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.
 - ◆ When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.

When a rate is not published by CMS for the service, the Claims Administrator uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, the Claims Administrator will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

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

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drugs*.

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

When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drugs*.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of- Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Care Coordination SM	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - CARE COORDINATIONSM

What this section includes:

- An overview of the Care CoordinationSM program; and
- Covered Health Services for which you need to contact Care CoordinationSM.

UnitedHealthcare provides a program called Care CoordinationSM designed to encourage personalized, efficient care for you and your covered Dependents.

Care CoordinationSM nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available. A Care CoordinationSM nurse is notified when you or your provider calls the toll-free number on your ID card regarding an upcoming treatment or service.

Care CoordinationSM nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Care CoordinationSM program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Care CoordinationSM nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, a Care CoordinationSM nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Care CoordinationSM nurse to confirm that medications, needed equipment, or follow-up services are in place. The Care CoordinationSM nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Care CoordinationSM nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Care CoordinationSM nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Requirements for Notifying Care CoordinationSM

Network providers are generally responsible for notifying Care CoordinationSM before they provide certain services to you. However, there are some Network Benefits for which you are responsible for notifying Care CoordinationSM.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying Care CoordinationSM before you receive these Covered Health Services. In many cases, your Non-Network Benefits will be reduced if Care CoordinationSM is not notified.

The services that require Care CoordinationSM notification are:

- breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature;
- Clinical Trials;
- Congenital Heart Disease services;
- Durable Medical Equipment for items that will cost more than \$1,000 to purchase or rent;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay;
- maternity care that exceeds the delivery timeframes as described in Section 6, *Additional Coverage Details*;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - Autism Spectrum Disorder Services -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Pre-service notification is also required for Benefits provided for Applied Behavioral Analysis (ABA).
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment;

psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; and

- transplantation services.

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

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

Notification is required within one business day of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For notification timeframes, and reductions in Benefits that apply if you do not notify Care CoordinationSM, see Section 6, *Additional Coverage Details*.

Contacting Care Coordination is easy.

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

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to notify Care CoordinationSM before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

SECTION 5 - PLAN HIGHLIGHTS

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

Plan Features	Network	Non-Network
Annual Deductible		
■ Individual	\$2,500	\$5,000
■ Family (not to exceed the individual Annual Deductible amount per Covered Person)	\$5,000	\$10,000
Annual Out-of-Pocket Maximum		
■ Individual	\$5,000	\$10,000
■ Family (not to exceed the individual Annual Out-of-Pocket Maximum amount per Covered Person)	\$10,000	\$20,000
Lifetime Maximum Benefit¹ There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

¹Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:

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

This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Ambulance Services - Emergency Only	<i>Ground Transportation</i> 80% after you meet the Annual Deductible <i>Air Transportation</i> 80% after you meet the Annual Deductible	<i>Ground Transportation</i> 80% after you meet the Annual Deductible <i>Air Transportation</i> 80% after you meet the Annual Deductible
Cancer Resource Services (CRS)² ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	Not Covered
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries ■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Dental Services - Accident Only	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible
Durable Medical Equipment (DME)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Emergency Health Services	80% after you meet the Annual Deductible	80% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Home Health Care Up to 50 visits per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care Up to 360 days per lifetime	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Injections received in a Physician's Office	80% per injection	60% per injection after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	80% after you meet the Annual Deductible	Not Covered
Maternity Services	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Mental Health Services		
■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Physician's Office Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Neurobiological Disorders - Autism Spectrum Disorder Services		
■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
■ Physician's Office Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Obesity	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Outpatient Surgery, Diagnostic and Therapeutic Services		
■ Outpatient Surgery	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient Diagnostic Services		
- Preventive Lab and radiology/X-ray	100%	Not Covered
- Preventive mammography testing	100%	Not Covered
■ Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Outpatient Therapeutic Treatments	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Preventive Care Services		
■ Immunizations	100%	Not Covered
■ Physician Office Services	100%	Not Covered

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
■ Outpatient Diagnostic Services	100%	Not Covered
■ Breast Pumps	100%	Not Covered
Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient See Section 6, Additional Coverage Details, for visit limits	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Second Surgical Opinion	Same as Physician's Office Services - Sickness and Injury	Same as Physician's Office Services - Sickness and Injury
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 365 days per calendar year	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Spinal Treatment	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Substance Use Disorder Services		
■ Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
■ Physician's Office Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Transplantation Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Urgent Care Center Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

¹You must notify Care CoordinationSM, as described in Section 4, *Care CoordinationSM* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for notifying Care CoordinationSM before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

²These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*, *Physician Fees for Surgical and Medical Services*, *Hospital - Inpatient Stay*, *Surgery - Outpatient*, *Scopic Procedures - Outpatient Diagnostic and Therapeutic Lab*, *X-Ray and Diagnostics – Outpatient*, and *Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient*.

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to notify Care CoordinationSM before you receive them, and any reduction in Benefits that may apply if you do not call Care CoordinationSM.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Care CoordinationSM. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Ambulance Services - Emergency only

Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed.

Cancer Resource Services (CRS)

United Healthcare will arrange for access to certain of its Network providers participating in the Cancer Resource Services Program for the provision of oncology services. You may be referred to Cancer Resource Services by United Healthcare, or you may self refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of Benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and Supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.

In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program.

When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the described in Section 5, *Plan Highlights* under the headings *Physician's Office Services – Sickness and Injury*, *Professional Fees for Surgical and Medical Services*, *Hospital-Inpatient Stay*, *Outpatient Surgery*, *Diagnostic and Therapeutic Services* listed in this section.

Cancer Clinical Trials and related treatment and services are considered a Covered Health Service when such treatment and services are recommended and provided by a Physician in a cancer center. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials

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

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

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

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

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

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
 - certain Category B devices;
 - certain promising interventions for patients with terminal illnesses; and
 - other items and services that meet specified criteria in accordance with our medical and drug policies;

- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list 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). (Includes National Cancer Institute (NCI));
 - Centers for Disease Control and Prevention (CDC);
 - Agency for Healthcare Research and Quality (AHRQ);
 - Centers for Medicare and Medicaid Services (CMS);
 - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
 - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
 - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
 - ◆ comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
 - ◆ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before

participants are enrolled in the trial. UnitedHealthcare 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.

Please remember that you must notify Care CoordinationSM as soon as the possibility of participation in a clinical trial arises. If Care CoordinationSM is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Congenital Heart Disease (CHD) Surgeries

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

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

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Care CoordinationSM to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Care CoordinationSM at the toll-free number on your ID card for information about CHD services.

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

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

Dental Services - Accident Only

Dental services when all of the following are true:

- treatment is necessary because of accidental damage;
- dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.";
- the dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

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

Dental services for final treatment to repair the damage must be both of the following:

- started within three months of the accident.
- completed within 12 months of the accident.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities.

Please remember that you should notify Care CoordinationSM as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to provide notification before the initial Emergency treatment. When you provide notification, Care CoordinationSM can determine whether the service is a Covered Health Service.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that meets each of the following:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable; and
- not of use to a person in the absence of a disease or disability.

If more than one piece of DME can meet your functional needs, Benefits are available only for the most Cost-Effective piece of equipment.

Examples of DME include but are not limited to:

- equipment to assist mobility, such as a standard wheelchair;
- a standard Hospital-type bed;
- oxygen concentrator units and the rental of equipment to administer oxygen;
- delivery pumps for tube feedings;
- braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an Injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).

UnitedHealthcare provides Benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM if the purchase, rental, repair or replacement of DME will cost more than \$1,000. If Care CoordinationSM is not notified, you will be responsible for paying all charges and no Benefits will be paid.

Emergency Health Services - Outpatient

The Plan pays for services that are required to stabilize or initiate treatment in an Emergency. Emergency health services must be received on an outpatient basis at a Hospital or Alternate Facility.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Care CoordinationSM is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

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

Please remember for Non-Network Benefits, you must notify Care CoordinationSM within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. If Care CoordinationSM is not notified, Benefits for the Inpatient Hospital Stay will be reduced to 50% of Eligible Expenses.

Home Health Care

Covered Health Services are services received from a Home Health Agency that are both of the following:

- ordered by a Physician; and
- provided by or supervised by a registered nurse in your home.

Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.

Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

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

Any combination of Network Benefits and Non-Network Benefits is limited to 50 visits per calendar year. One visit equals four hours of Skilled Care services.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM five business days before receiving services or as soon as reasonably possible. If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospice Care

The Plan pays Benefits for hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, respite and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Any combination of Network Benefits and Non-Network Benefits is limited to 360 days per Covered Person during the entire period you are covered under the Plan.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM five business days before receiving services. If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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

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

Please remember for Non-Network Benefits, you must notify Care CoordinationSM as follows:

- for elective admissions: five business days before admission or as soon as reasonably possible;
- for Emergency admissions (also termed non-elective admissions): within one business day or the same day of admission, or as soon as is reasonably possible.

If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Injectors received in a Physician's Office

The Plan pays for Benefits for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.

Kidney Resource Services (KRS)

UnitedHealthcare will arrange for access to certain of its Network Providers participating in the Kidney Resource Services Program for End Stage Renal Disease (ESRD) and chronic kidney disease. You may be referred to KRS by UnitedHealthcare, or you may self refer to KRS by calling 888-936-7246 and select the KRS prompt. In order to receive the highest level of Benefits, you must contact KRS prior to obtaining Covered Health Services. The services include Covered Health Services and supplies rendered for the treatment and/or diagnosis relating to ESRD or chronic kidney disease.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

When these services are not performed in a KRS facility, Benefits will be paid the same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services listed in this section.

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Maternity Services

Employee and Dependent Spouse Only

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth.

UnitedHealthcare will pay Benefits for an Inpatient Stay of at least:

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

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

For Dependent Children Only

Pregnancy Benefits for Dependent children are limited to Covered Health Services for Complications of Pregnancy. For a complete definition of Complications of Pregnancy, see Section 14, *Glossary*.

Benefits are payable for Covered Health Services for the treatment of Complications of Pregnancy given to a Dependent child while covered under this Plan.

Benefits for Complications of Pregnancy are paid in the same way as benefits are paid for Sickness.

Benefits for Complications of Pregnancy which result in the delivery of a child are payable for at least:

- 48 hours of inpatient care for the mother and newborn child following a normal vaginal delivery; and

- 96 hours of inpatient care for the mother and newborn child following a cesarean section.

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

The following are not considered Complications of Pregnancy:

- false labor;
- occasional spotting;
- rest prescribed by a Physician;
- morning sickness; and
- other conditions that may be connected with a difficult pregnancy but are not a classifiably distinct complication.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If Care CoordinationSM is not notified, Benefits for the extended stay will be reduced to 50% of Eligible Expenses.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

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

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

Special Mental Health Programs and Services

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

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please refer to Section 4, *Care Coordination*SM for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the *Enhanced Autism Spectrum Disorder* benefit below.

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

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;

- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder Benefits

Covered Health Services include enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

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

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

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Care CoordinationSM* for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Obesity

The Plan pays for Benefits for hospital, physician, and diagnostic fees associated with morbid obesity if:

- The Participant has a Body Mass Index equal to or greater than 35 and said index has been met for the three years prior to the date of surgery;
- The Participant has at least one co-morbidity that is a direct complication of obesity and that has been previously unsuccessfully treated (this requirement is waived for individuals with a Body Mass Index greater than 40);
- The Participant has, within the 24 months prior to surgery, previously completed one physician supervised weight loss attempt, for a duration no less than six months, that included behavioral therapy, diet changes, and alteration of physical activity when indicated and has been unsuccessful in this effort;

- No previous bariatric surgery for weight reduction.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in Section 14, *Glossary* and are not Experimental or Investigational or Unproven Services.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.

Outpatient Surgery, Diagnostic and Therapeutic Services

Outpatient Surgery

The Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Outpatient Diagnostic Services

The Plan pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

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

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

This section does not include Benefits for CT scans, PET scans, MRIs, or nuclear medicine, which are described immediately below.

Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine

The Plan pays for Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

Outpatient Therapeutic Treatments

The Plan pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment, and all related professional fees.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

Physician's Office Services - Sickness and Injury

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

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

Please Note

Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Preventive Care Services

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

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 6, *Plan Highlights*, under *Covered Health Services*.

Benefits are only available if breast pumps are obtained from a DME provider.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. The Claims Administrator will determine the following:

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

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Professional Fees for Surgical and Medical Services

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.

Prosthetic Devices

External prosthetic devices that replace a limb or an external body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function.

Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

Please remember that for Non-Network Benefits you must notify Care CoordinationSM five business days before undergoing a Reconstructive Procedure. When you provide notification, Care CoordinationSM can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Rehabilitation Services - Outpatient Therapy

The Plan provides short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician (when required by state law). Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

Please note that the Plan will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

Habilitative Services

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

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

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

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable

progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

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

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

Benefits are limited to:

- 20 visits per calendar year for pulmonary rehabilitation therapy; and
- 36 visits per calendar year for cardiac rehabilitation therapy.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Second Surgical Opinion

This is not a required service to obtain Benefits.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

The Plan pays for Covered Health Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- services and supplies received during the Inpatient Stay; and
- room and board in a Semi-private Room (a room with two or more beds).

Any combination of Network Benefits and Non-Network Benefits is limited to 365 days per calendar year.

Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital.

Please remember for Non-Network Benefits, you must notify Care CoordinationSM as follows:

- for elective admissions: five business days before admission;
- for non-elective admission: within one business day or the same day of admission; and
- for Emergency admissions: as soon as is reasonably possible.

If Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Spinal Treatment

Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.

Benefits include diagnosis and related services and are limited to one visit and treatment per day.

Coverage is limited to charges incurred.

Spinal Treatment consists of spinal adjustment for acute or chronic subluxation and includes charges for x-rays and other services authorized or recommended by a chiropractor operating within the scope of his license.

Maintenance and preventive care are not covered.

No benefits for Spinal Treatment will be paid under any other section of the Plan.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and

■ Intensive Outpatient Treatment.

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

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

Special Substance Use Disorder Programs and Services

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

Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Care Coordination*SM for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses.

Transplantation Services

Covered Health Services for organ and tissue transplants when ordered by a Physician. For Network Benefits, transplantation services must be received at a Designated Facility. Transplantation services provided at a non-Designated Facility will be covered as Non-Network Benefits. Benefits are available when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service:

Notification is required for all transplant services.

The Annual Deductible will not apply to Network Benefits when a transplant listed below is received at a Designated Facility. The services described under *Transportation and Lodging* below are Covered Health Services **ONLY** in connection with a transplant received at a Designated Facility.

Examples of transplants for which Benefits are available include but are not limited to:

- bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a Designated Facility.
- heart transplants;
- heart/lung transplants;
- lung transplants;
- kidney transplants;
- kidney/pancreas transplants;
- liver transplants;
- liver/small bowel transplants;
- pancreas transplants; and
- small bowel transplants.

Benefits for cornea transplants that are provided by a Network Physician at a Network Hospital are paid as if the transplant was received at a Designated Facility. Cornea transplants are not required to be performed at a Designated Facility in order for you to receive Network Benefits. Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

Non-Network Benefits are limited to \$25,000 per transplant.

Please remember for Non-Network Benefits, you must notify United Resource Networks or Care CoordinationSM as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If United Resource Networks or Care CoordinationSM is not notified, Benefits will be reduced to 50% of Eligible Expenses.

Urgent Care Center Services

The Plan pays for Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:

Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

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

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

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and City of Columbia, Missouri are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Assessment

You and your Spouse are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – City of Columbia, Missouri's way of helping you meet your health and wellness goals.

NurseLineSM

NurseLineSM is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that City of Columbia, Missouri has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLineSM gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLineSM is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLineSM.

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLineSM toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLineSM to help answer your health questions.

With NurseLineSM, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

UnitedHealth PremiumSM Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth PremiumSM Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth PremiumSM Program was designed to:

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

For details on the UnitedHealth PremiumSM Program including how to locate a UnitedHealth PremiumSM Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

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

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

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

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Diabetes Prevention and Control

UnitedHealthcare provides two programs that identify, assess, and support members over the age of 18 living with diabetes or pre-diabetes. The program is designed to support members in preventing pre-diabetics from progressing to diabetes and assist members living with diabetes in controlling their condition and from developing complications.

The Diabetes Prevention Program (DPP) is available for members living with pre-diabetes and offers a 16 session lifestyle intervention that addresses diet, activity and behavior

modification. The goal of this program is to slow and/or prevent the development of Type 2 diabetes through lifestyle management and weight loss and is available at local YMCAs.

The Diabetes Control Program (DCP) is available to members living with diabetes and offers face-to-face consultations with trained local pharmacists who will review diabetes history and medication, provide diabetes management education materials and assist individuals living with diabetes with managing their condition. The goal of this program is to reduce the risk of serious health complications through medication management and ongoing monitoring for complications.

Participation is completely voluntary and without extra charge. There are no Copays, Coinsurance or Deductibles that need to be met when services are received as part of the DPP or DCP programs. If you think you may be eligible to participate or would like additional information regarding the programs, please call the DPCA call center directly at (888) 688-4019.

HealtheNotesSM

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;

- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for any of the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure and acupuncture;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. rolfing;
6. other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

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

5. supplies, equipment and similar incidental services and supplies for personal comfort.
Examples include:

- air conditioners;
- air purifiers and filter;
- batteries and battery chargers;
- dehumidifiers;
- humidifiers.
- devices and computers to assist in communication and speech.

Dental

1. dental care, except as described in Section 6, *Additional Coverage Details* under the heading *Dental Services - Accident only*

2. preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums.
Examples include all of the following:

- extraction, restoration and replacement of teeth;
- medical or surgical treatments of dental conditions;
- services to improve dental clinical outcomes.

3. dental implants.

4. dental braces.

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:

- transplant preparation;
- initiation of immunosuppressives;
- the direct treatment of acute traumatic Injury, cancer or cleft palate.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 5, *Additional Coverage Details*.

6. treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a Congenital Anomaly.

Drugs

1. prescription drug products for outpatient use that are filled by a prescription order or refill;
2. self-injectable medications;
3. non-injectable medications given in a Physician's office except as required in an Emergency;

4. over the counter drugs and treatments.

Experimental or Investigational Services or Unproven Services

Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service or an Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes. Routine foot care services that are not covered include:
 - cutting or removal of corns and calluses;
 - nail trimming or cutting; and
 - debriding (removal of dead skin or underlying tissue);
2. hygienic and preventive maintenance foot care. Examples include the following:
 - cleaning and soaking the feet;
 - applying skin creams in order to maintain skin tone;
 - other services that are performed when there is not a localized illness, Injury or symptom involving the foot;
3. treatment of flat feet;
4. treatment of subluxation of the foot;
5. shoe orthotics.

Medical Supplies and Appliances

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - elastic stockings;
 - ace bandages;
 - gauze and dressings;
 - syringes;

- diabetic test strips;
- 3. orthotic appliances that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter.

- 4. cranial banding;
- 5. tubings and masks are not covered except when used with Durable Medical Equipment as described in Section 6, *Additional Coverage Details* under the heading *Durable Medical Equipment*.

Mental Health and Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

- 1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- 2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance-related and addictive disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
 - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
 - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
 - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; and
 - not clinically appropriate for the patient's Mental Illness, substance-related and addictive disorder or condition based on generally accepted standards of medical practice and benchmarks; and
- 3. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- 4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;
- 5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
8. learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
9. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
11. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction; and
13. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. megavitamin and nutrition based therapy;
2. Individual and group nutritional counseling. This exclusion does not apply to nutritional counseling services that are billed as Preventive Care Services or to nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - nutritional education is required for a disease in which patient self-management is an important component of treatment; and
 - there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional;
2. enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
3. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:
 - pharmacological regimens, nutritional procedures or treatments;
 - scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
 - skin abrasion procedures performed as a treatment for acne;
2. replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. **Note:** Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;
3. physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation;
4. weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded;
5. wigs regardless of the reason for the hair loss.

Providers

1. services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself;
2. services performed by a provider with your same legal residence;
3. services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
 - has not been actively involved in your medical care prior to ordering the service; or
 - is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments;
2. surrogate parenting;
3. the reversal of voluntary sterilization;
4. maternity services, including delivery, for Dependent children, except those that have Complications of Pregnancy as defined in Section 14, *Glossary*.

Services Provided under Another Plan

1. health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you;
3. health services while on active military duty.

Transplants

1. health services for organ, multiple organ and tissue transplants, except as described in *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.);
3. health services for transplants involving mechanical or animal organs;
4. any solid organ transplant that is performed as a treatment for cancer.

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services;
2. travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

Vision and Hearing

1. purchase cost of eye glasses, contact lenses or hearing aids;
2. fitting charge for hearing aids, eye glasses or contact lenses;
3. eye exercise or vision therapy;
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery;

5. Routine vision examinations, including refractive examinations;
6. purchase cost and associated fitting and testing charges for hearing aids, Bone Anchor Hearing Aids (BAHA) and all other hearing assistive devices.

All Other Exclusions

1. health services and supplies that do not meet the definition of a Covered Health Service
- see the definition in Section 14, *Glossary*;

This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;

2. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when;
 - required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption;
 - related to judicial or administrative proceedings or orders;
 - conducted for purposes of medical research; This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*;
 - required to obtain or maintain a license of any type;
3. health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
4. health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends;
5. health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan;
6. in the event that a non-Network provider waives the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Annual Deductible is waived;
7. charges in excess of Eligible Expenses or in excess of any specified limitation;
8. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature;
9. upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea;
10. Surgical treatment of obesity excluding severe morbid obesity: (with a BMI equal to or greater than 35) and the said index has been met for three years prior to the date of the scheduled surgery.

11. Non-surgical treatment of obesity including dietary supplements or supplies used in conjunction with weight loss.
12. growth hormone therapy;
13. sex transformation operations;
14. Custodial Care;
15. domiciliary care;
16. private duty nursing;
17. respite care;
18. rest cures;
19. psychosurgery;
20. treatment of benign gynecomastia (abnormal breast enlargement in males);
21. medical and surgical treatment of excessive sweating (hyperhidrosis);
22. panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction. This exclusion does not apply to breast reconstruction following a mastectomy as described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*;
23. medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea;
24. oral appliances for snoring;
25. speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly;
26. any charges for missed appointments, room or facility reservations, completion of claim forms or record processing;
27. any charge for services, supplies or equipment advertised by the provider as free;
28. any charges prohibited by federal anti-kickback or self-referral statutes.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

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

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

Prescription Drug Benefit Claims

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

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Coinsurance and you believe that the amount of the Coinsurance was incorrect.

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

If Your Provider Does Not File Your Claim

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

- Your name and address.
- The patient's name, age and relationship to the Participant.

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

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

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

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

You may not assign your Benefits under the Plan to a non-Network provider without UnitedHealthcare's consent. When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Participant) for you to reimburse the non-Network provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the non-Network provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the non-Network provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your Provider. Direct payment to a non-Network provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a non-Network provider, you remain the sole beneficiary of the payment, and the non-Network provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the non-Network provider as well. If payment to a non-Network provider is made, the Plan reserves the right to offset Benefits to

be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 10 *Coordination of Benefits*.

Health Statements

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

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

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

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

Claim Denials and Appeals

If Your Claim is Denied

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

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;

- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

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

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

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

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

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

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

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from City of Columbia, Missouri within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. City of Columbia, Missouri will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by City of Columbia, Missouri, or if City of Columbia, Missouri fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of City of Columbia, Missouri's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

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

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received City of Columbia, Missouri's decision.

An external review request should include all of the following:

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

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

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

Standard External Review

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

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and

- a decision by the IRO.

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

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

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

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

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making City of Columbia, Missouri's determination. The documents include:

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

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

Upon receipt of a Final External Review Decision reversing City of Columbia, Missouri determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral

will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

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

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

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

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

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

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by City of Columbia, Missouri. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72

hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

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

Timing of Appeals Determinations

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

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

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

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

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

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	30 days
■ after receiving the completed claim (if the initial claim is incomplete), within:	30 days

Post-Service Claims	
Type of Claim or Appeal	Timing
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
City of Columbia, Missouri must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

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

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

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

Limitation of Action

You cannot bring any legal action against City of Columbia, Missouri or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against City of Columbia, Missouri or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against City of Columbia, Missouri or the Claims Administrator.

You cannot bring any legal action against City of Columbia, Missouri or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against City of Columbia, Missouri or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you

lose any rights to bring such an action against City of Columbia, Missouri or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

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

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

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

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the Spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the Spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

- 1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
- 2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.
- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare); and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A carriers have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the telephone number listed on the back of your ID card.

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. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

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

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary,

wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the Claims Administrator makes payments, with the understanding that the Claims Administrator will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall 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 Sickness or Injury for which a third party is alleged to be responsible.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness 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 received for that Sickness or Injury.

Reimbursement – Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- 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; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its 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 which 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 its agents reasonably request to secure the subrogation and reimbursement claim;
- responding to requests for information about any accident or injuries;
- making court appearances;
- obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
- complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, 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 Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which 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, the Plan's 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 or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive 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, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those

funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation 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, 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 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.
- 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, shall 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 a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

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.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;

- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage;
- Conversion from a group policy to an individual policy; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, City of Columbia, Missouri will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

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

- the last day of the month your employment with the Company ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible;
- the last day of the month UnitedHealthcare receives written notice from City of Columbia, Missouri to end your coverage, or the date requested in the notice, if later; or
- the last day of the month you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month UnitedHealthcare receives written notice from City of Columbia, Missouri to end your coverage, or the date requested in the notice, if later; or
- the last day of the month your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to City of Columbia, Missouri's staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: City of Columbia, Missouri has the right to demand that you pay back Benefits City of Columbia, Missouri paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to City of Columbia, Missouri proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon City of Columbia, Missouri's request, that the child continues to meet these conditions.

The proof might include medical examinations at City of Columbia, Missouri's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Extended Coverage for Total Disability

If a Covered Person has a Total Disability on the date their coverage under the Plan ends, their Benefits will not end automatically. The Plan will temporarily extend coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of:

- the Total Disability ends; or
- twenty nine months from the date coverage would have ended.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if City of Columbia, Missouri is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Participant;
- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ¹	29 months	29 months	29 months
You die	N/A	36 months	36 months

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
City of Columbia, Missouri files for bankruptcy under Title 11, United States Code. ²	36 months	36 months ³	36 months ³

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

²This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Human Resources with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 16, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

- you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;
- you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;
- the first required premium is not paid within 45 days;
- any other monthly premium is not paid within 30 days of its due date;
- the entire Plan ends; or
- coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Conversion from a Group Plan to an Individual Plan

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage, without furnishing evidence of insurability, if:

- you are no longer eligible as a Participant or enrolled Dependent; or
- continuation coverage ends.

This right to conversion coverage is contingent upon the exhaustion of COBRA continuation coverage.

In addition, you may not be eligible for conversion coverage if you are:

- age 65 or older;
- covered under or eligible for coverage under Medicare (title XVIII as amended); or
- covered under or eligible for any group, individual, prepayment, government, or other plan or program which would result in overinsurance if conversion coverage was issued.

You must submit your first application and payment to UnitedHealthcare or its designated insurance company within 31 days after coverage ends under this Plan. UnitedHealthcare or its designated insurance company will issue conversion coverage according to the terms and conditions in effect at the time you apply. Conversion coverage may be substantially different from coverage provided under this Plan. Even though you may be eligible for conversion coverage, UnitedHealthcare does not offer conversion products in certain states.

When a conversion product is not available, the conversion coverage may be provided by a state sponsored risk pool.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Participant's absence from work; or
- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and City of Columbia, Missouri;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and City of Columbia, Missouri

In order to make choices about your health care coverage and treatment, City of Columbia, Missouri believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- City of Columbia, Missouri and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and

- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

City of Columbia, Missouri and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. City of Columbia, Missouri and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. City of Columbia, Missouri and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between City of Columbia, Missouri, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not City of Columbia, Missouri's agents or employees, nor are they agents or employees of UnitedHealthcare. City of Columbia, Missouri and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

City of Columbia, Missouri and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, City of Columbia, Missouri and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not City of Columbia, Missouri's employees nor are they employees of UnitedHealthcare. City of Columbia, Missouri and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. City of Columbia, Missouri and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

City of Columbia, Missouri is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;

- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

City of Columbia, Missouri and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

City of Columbia, Missouri and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, City of Columbia, Missouri may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that City of Columbia, Missouri does so in any particular case shall not in any way be deemed to require City of Columbia, Missouri to do so in other similar cases.

Information and Records

City of Columbia, Missouri and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. City of Columbia, Missouri and UnitedHealthcare may request additional information from you to decide your claim for Benefits. City of Columbia, Missouri and UnitedHealthcare will keep this information confidential. City of Columbia, Missouri and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish City of Columbia, Missouri and UnitedHealthcare with all information or copies of records relating to the services provided to you. City of Columbia, Missouri and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. City of Columbia, Missouri and UnitedHealthcare agree that such information and records will be considered confidential.

City of Columbia, Missouri and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as City of Columbia, Missouri is required to do by law or regulation. During and after the term of the Plan, City of Columbia, Missouri and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements City of Columbia, Missouri recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

In some cases, City of Columbia, Missouri and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but City of Columbia, Missouri recommends that you discuss participating in such programs with your Physician. These incentives are not

Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

City of Columbia, Missouri and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. City of Columbia, Missouri and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 14 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

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

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 5, *Plan Highlights*. The Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Prescription Drugs*.

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Columbia, Missouri. The CRS program provides:

- specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Care CoordinationSM – programs provided by UnitedHealthcare that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – City of Columbia, Missouri.

Complications of Pregnancy – a condition suffered by a Dependent child that requires medical treatment before or after Pregnancy ends.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services or supplies, which UnitedHealthcare determines to be:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- included in Sections 5 and 6, *Plan Highlights* and *Additional Coverage Details*;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

The Claims Administrator maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on www.myuhc.com or by calling the number on the back of your ID card. This information is available to Physicians and other health care professionals on UnitedHealthcareOnline.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between a Participant and one other person of the same or opposite sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:
 - they have a single dedicated relationship of at least 6 months duration;
 - they have joint ownership of a residence; or
 - they have at least two of the following:
 - ◆ a joint ownership of an automobile;
 - ◆ a joint checking, bank or investment account;
 - ◆ a joint credit account;
 - ◆ a lease for a residence identifying both partners as tenants; or
 - ◆ a will and/or life insurance policies which designate the other as primary beneficiary.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by Human Resources upon your request.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and

- appropriate for use, and primarily used, within the home.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines. The Claims Administrator develops the reimbursement policy guidelines, in the Claims Administrator's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance use disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – City of Columbia, Missouri.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator and City of Columbia, Missouri make a determination regarding coverage in a particular case, are determined to be any of the following:

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

- Subject to review and approval by any institutional review board for the proposed use (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical Trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator and City of Columbia, Missouri may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator and City of Columbia, Missouri must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by City of Columbia, Missouri. The KRS program provides:

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by City of Columbia, Missouri who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period of time, determined by City of Columbia, Missouri, during which eligible Participants may enroll themselves and their Dependents under the Plan. City of Columbia, Missouri determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The City of Columbia, Missouri Medical Plan.

Plan Administrator – City of Columbia, Missouri or its designee.

Plan Sponsor – City of Columbia, Missouri.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;

- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
 - room and board;
 - evaluation and diagnosis;
 - counseling; and
 - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retired Employee – an Employee who retires while covered under the Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

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

- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spinal Treatment – detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Total Disability – a Participant's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium ProgramSM – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium ProgramSM Physician or facility for certain medical conditions.

To be designated as a UnitedHealth PremiumSM provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium ProgramSM Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare and City of Columbia, Missouri may, at their discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare and City of Columbia, Missouri must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare and City of Columbia, Missouri's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order 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 Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Coinsurance amounts that apply when you have a prescription filled at a Network or non-Network Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*. The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*.

Covered Health Services ^{1,2}	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Retail - up to a 90-day supply		
■ tier-1	80%	80%
■ tier-2	80%	80%
■ tier-3	80%	80%
Specialty Prescription Drugs - up to 31-day supply		
■ tier-1	80%	Not Covered
■ tier-2	80%	Not Covered

Covered Health Services ^{1,2}	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Non-Network
■ tier-3	80%	Not Covered
Mail order - up to a 90-day supply		
■ tier-1	80%	Not Covered
■ tier-2	80%	Not Covered
■ tier-3	80%	Not Covered

¹You, your Physician or your pharmacist must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

²You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* does not apply to covered Prescription Drugs as described in this section. Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

Identification Card (ID Card) – Network Pharmacy

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

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

Benefit Levels

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

The Plan pays Benefits at the same level for tier-1, tier-2 and 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 can change periodically, generally quarterly but no more than six times per calendar year, 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, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Coinsurance, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Coinsurance will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- 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.
- Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

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

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

- the applicable Coinsurance;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Charge that UnitedHealthcare agreed to pay the Network Pharmacy.

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

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

Retail

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

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Coinsurance. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 90-day supply, the Coinsurance that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay the Coinsurance for each cycle supplied.

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

Mail Order

The mail order 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 mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. 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 UnitedHealthcare at the toll-free number on your ID card.

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

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

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

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

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drugs*. You may determine whether a drug is a Preventive

Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Designated Pharmacy

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

Specialty Prescription Drugs

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

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy.

Select Designated Pharmacy

You may fill a prescription for a Select Prescription Drug up to two times at any retail Pharmacy. However, after that you will be directed to a Designated Pharmacy. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug from a Designated Pharmacy, non-Network Benefits will apply for that Select Prescription Drug.

For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Please see the Prescription Drug Glossary in this section for the definition of Select Prescription Drug.

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

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

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

Economic factors may include:

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

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

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

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

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

Prescription Drug List (PDL)

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

Notification Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify UnitedHealthcare. UnitedHealthcare will determine if the Prescription Drug, in accordance with UnitedHealthcare approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

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

Network Pharmacy Notification

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying the Claims Administrator.

Non-Network Pharmacy Notification

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

If UnitedHealthcare is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. If

UnitedHealthcare is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

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

To determine if a Prescription Drug requires notification, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring notification are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

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

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

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

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator 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 Coinsurance may change. You will pay the Coinsurance applicable for the tier to which the Prescription Drug is assigned.

Special Programs

City of Columbia, Missouri and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

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

Rebates and Other Discounts

UnitedHealthcare and City of Columbia, Missouri may, at times, receive rebates for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Coinsurance.

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

Coupons, Incentives and Other Communications

UnitedHealthcare may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition.

UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information

on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions* apply also to this section8, . In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drugs, you can access **www.myuhc.com** through the Internet or by calling the telephone number on your ID card for information on which Prescription Drugs are excluded.

Medications that are:

1. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
2. any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;
5. 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 contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3;
6. dispensed outside of the United States, except in an Emergency;

7. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
8. for smoking cessation;
9. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition);
10. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
11. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;
12. certain Prescription Drugs that have not been prescribed by a specialist physician;
13. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
14. prescribed, dispensed or intended for use during an Inpatient Stay;
15. prescribed for appetite suppression, and other weight loss products;
16. prescribed to treat infertility;
17. Prescription Drugs, including new Prescription Drugs or new dosage forms, that UnitedHealthcare and City of Columbia, Missouri determines do not meet the definition of a Covered Health Service;
18. Prescription Drugs when prescribed as sleep aids;
19. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;
20. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug;
21. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;
22. unit dose packaging of Prescription Drugs;
23. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and City of Columbia, Missouri have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;
24. used for cosmetic purposes;

25. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed; and
26. vitamins, except for the following which require a prescription:
- prenatal vitamins;
 - vitamins with fluoride; and
 - single entity vitamins.

Glossary - Prescription Drugs

Brand-name - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Designated Pharmacy – a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Claims Administrator as a Network Pharmacy.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Predominant Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. The Claims Administrator calculates the Predominant Reimbursement Rate using its Prescription Drug Charge that applies for that particular Prescription Drug at most Network Pharmacies.

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

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
 - insulin syringes with needles;
 - blood testing strips - glucose;
 - urine testing strips - glucose;
 - ketone testing strips and tablets;
 - lancets and lancet devices;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
 - glucose monitors.

Prescription Drug Charge – the rate the Claims Administrator 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) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto www.myuhc.com.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Select Prescription Drug - a Prescription Drug that is generally a tier-3 drug with lower-tiered alternatives used to treat the same condition. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Specialty Prescription Drug - Prescription Drug that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

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

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

What this section includes:

- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Claims Administrator: The company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is City of Columbia, Missouri, the Plan Sponsor.

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II – LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- 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 treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any 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 delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

ATTACHMENT III - HEALTH SAVINGS ACCOUNT

What this attachment includes:

- About Health Savings Accounts;
- Who is eligible and how to enroll;
- Contributions;
- Additional medical expense coverage available with your Health Savings Account;
- Using the HSA for Non-Qualified Expenses; and
- Rolling over funds in your HSA.

Introduction

This attachment to the Summary Plan Description (SPD) describes some key features of the Health Savings Account (HSA) that you could establish to complement the , which is a high deductible medical plan. In particular, and except as otherwise indicated, this attachment will address the Health Savings Account, and not the high deductible health plan that is associated with the "HSA".

City of Columbia, Missouri has entered into an agreement with United HealthCare Services, Inc., Minnetonka, MN, ("UnitedHealthcare") under which UnitedHealthcare will provide certain administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this attachment. Further, note that it is the Plan's intention to comply with Department of Labor guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

The HSA described in this section is not an arrangement that is established and maintained by City of Columbia, Missouri. Rather, the HSA is established and maintained by the HSA trustee. However, for administrative convenience, a description of the HSA is provided in this section.

About Health Savings Accounts

You gain choice and control over your health care decisions and expenditures when you establish your HSA to complement the high deductible medical plan described in the SPD.

An HSA is an account funded by you, your employer, or any other person on your behalf. The HSA can help you to cover, on a tax free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles, Copayments or Coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. Amounts may be distributed from the HSA to pay non-medical expenses, however, these amounts are subject to income tax and may be subject to 20 percent penalty.

You have three tools you can use to meet your health care needs:

- a high deductible medical plan which is discussed in your Summary Plan Description;
- an HSA you establish; and
- health information, tools and support.

Benefits available under your medical plan are described in your medical plan Summary Plan Description (SPD).

What is an HSA?

An HSA is a tax-advantaged account Participants can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible medical plan. HSA contributions:

- accumulate over time with interest or investment earnings;
- are portable after employment; and
- can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

Who Is Eligible And How To Enroll

Eligibility to participate in the Health Savings Account is described in the SPD for your high deductible medical plan. You must be covered under a high deductible medical plan in order to participate in the HSA. In addition, you:

- must not be covered by any high deductible medical plan considered non-qualified by the IRS. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- must not participate in a full health care Flexible Spending Account (FSA);
- must not be entitled to Benefits under Medicare (i.e., enrolled in Medicare); and
- must not be claimed as a dependent on another person's tax return.

Contributions

Contributions to your HSA can be made by you, by your employer or by any other individual. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum.

Note that if coverage under a qualified high deductible health plan terminates, no further contributions may be made to the HSA.

The contribution maximum is the single and family limits set by federal regulations. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to the maximum allowed by federal regulations. The maximum limits set by federal regulations may be found on the IRS website at www.irs.gov.

If you enroll in your HSA within the year (not on January 1) you will still be allowed to contribute the maximum amount set by federal regulations. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month from your initial enrollment or you will be subject to tax implications and an additional tax of 10%.

Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an "excess contribution" prior to April 15th of the following year.

Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible dependents' out-of-pocket costs under the medical plan, including Annual Deductibles, Copayments and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". Please see the description of *Additional Medical Expense Coverage Available With Your Health Savings Account* below, for additional information. HSA funds used for such purposes are not subject to income or excise taxes.

"Qualified health expenses" only include the medical expenses of you and your eligible dependents, meaning your spouse and any other family members whom you are allowed to file as dependents on your federal tax return, as defined in Section 152 of the Internal Revenue Code of 1986, as amended from time to time.

HSA funds may also be used to pay for non-qualified health expenses but will generally be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

Additional Medical Expense Coverage Available with Your Health Savings Account

A complete description of, and a definitive and current list of what constitutes eligible medical expenses, is available in IRS Publication 502 which is available from any regional IRS office or IRS website.

If you receive any additional medical services and you have funds in your HSA, you may use the funds in your HSA to pay for the medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services.

The monies paid for these additional medical expenses will not count toward your Annual Deductible or Out-of-Pocket Maximum.

Using the HSA for Non-Qualified Expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums.

Rollover Feature

If you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the accompanying high deductible health plan, as described in your medical plan SPD.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Important

Be sure to keep your receipts and medical records. If these records verify that you paid qualified health expenses using your HSA, you can deduct these expenses from your taxable income when filing your tax return. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. City of Columbia, Missouri and UnitedHealthcare will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

The IRS may request receipts during a tax audit. City of Columbia, Missouri and the Claims Administrator are not responsible or liable for the misuse by Participants of HSA funds by, or for the use by Participants of HSA funds for non-qualified health expenses.

Additional Information About the HSA

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance.

Upon request from a health care professional, UnitedHealthcare and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will UnitedHealthcare provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this

information disclosed, you must notify the Claims Administrator and the financial institution in writing.

You can obtain additional information on your HSA online at www.irs.gov. You may also contact your tax advisor. Please note that additional rules may apply to a Dependent's intent to opening an HSA.

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:

You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

ParentSteps is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps will collect the provider payment from you online via the ParentSteps website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services (described in the Summary Plan Description Section 5, *Plan Highlights*) when a benefit is available.

What is ParentSteps?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at www.myoptumhealthparentsteps.com or by calling ParentSteps toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see the

specific rates negotiated by ParentSteps with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps member. ParentSteps will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps discounts apply, the provider will enter in your proposed course of treatment. ParentSteps will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps Information

Additional information on the ParentSteps program can be obtained online at www.myoptumhealthparentsteps.com or by calling 1-877-801-3507 (toll-free).

Group Dental Plan

Summary Plan Description



DEARBORN NATIONAL ® LIFE INSURANCE COMPANY
Downers Grove, Illinois

CITY OF COLUMBIA, MISSOURI

Group Number: F018532-0001

Class 1-01

Products and services marketed under the Dearborn National brand and the star logo are underwritten and/or provided by Dearborn National Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands and Guam.

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INTRODUCTION

This Group Dental Plan (Plan) offers dental coverage to you and your dependents. This Plan has been designed and selected by the Plan Administrator as one of the benefits of Your employment. The Plan is a self-funded employee benefit plan organized and operated under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA) and is administered by the City of Columbia, Missouri, who may also be referred to as the Plan Administrator. The claim administrator for the Plan is Dearborn National Life Insurance Company ("Dearborn National").

If you meet the Plan's eligibility requirements, you or your covered dependents can choose a dentist in the Dearborn National Preferred Provider Organization (PPO) Network. A PPO network is a network of dentists who have accepted lower negotiated fees for their services. When you use a Dearborn National PPO dentist, you can take advantage of these lower fees and reduce the expenses that accrue toward your annual maximum benefit limit.

This booklet is a Summary Plan Description (SPD) which highlights provisions of the Plan. This booklet provides details about the claims appeal process, your COBRA rights, Plan administration and your rights under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. From time to time, you may receive other written communications about the Plan or about certain provisions of the Plan.

If you have questions regarding the benefits covered under the Plan, refer to the Plan document available to your employer. You may obtain a copy of the Plan document by requesting a copy from your employer. You may be required to pay reasonable copying costs for the Plan document.

If you have questions about the information in this booklet, call the Plan Administrator. .

SCHEDULE OF BENEFITS

The following Benefits are provided subject to the provisions below:

Effective Date: January 1, 2013

Employer Contribution: 100%

Class 01 Eligibility: All Active Eligible Employees who are scheduled to work at least 20 hours per week.

Dependent Age Limit: to the end of the year the Dependent Child turns age 26

Waiting Period: First of the month following date of hire.

DENTAL BENEFITS

DENTAL EXPENSE BENEFIT	AMOUNT	
	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Amount		
Individual	\$25	\$25
Family	No Limit	No Limit
Note: Deductible waived for Preventive and Diagnostic Services and Miscellaneous Services. Covered dental expenses incurred toward the deductible amount apply to both the In-Network and Out-of-Network Plan.		
Benefit Categories	Covered Percentage of Allowable Expenses	
Diagnostic and Preventive Care	100%	100%
Miscellaneous Services	100%	100%
Restorative Services	80%	80%
General Services	80%	80%
Endodontic Services	80%	80%
Periodontal Services	80%	80%
Oral Surgery Services	80%	80%
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment.)	80%	80%
Crowns, Inlays/Onlays Services	50%	50%
Prosthodontic Services	50%	50%
Implant Services	50%	50%

MAXIMUM CALENDAR YEAR BENEFITS	
Covered Dental Expenses	\$1,500
Note: Amounts applied to the benefit maximums will apply to both the In-Network and Out-of-Network.	

NOTES

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

IDENTIFICATION CARD

You will be issued an Identification Card. This card identifies You and any covered family members as Participants in the Dearborn National Dental Benefits Plan. Your card contains important information about You, the Plan Administrator, and the benefits to which You are entitled.

Always remember to carry Your Identification Card with You and present it to Your Dentist when receiving dental services or supplies. Dentists will use the information on Your card to file claims for You and any covered family members. Any time a change in Your family takes place, it may be necessary for a new Identification Card to be issued to You. Contact your Plan Administrator for more information. Upon receipt of the changed information, a new Identification Card will be issued and forwarded to your Plan Administrator for distribution to You.

ELIGIBILITY AND ENROLLMENT

WHO IS ELIGIBLE FOR COVERAGE?

Employee Eligibility

If you are in a class shown on the Schedule of Benefits and have completed the waiting period, if any, You may apply for coverage for Yourself and Your Eligible Dependent on or before Your Eligibility Date.

Dependent Eligibility

For the purposes of this provision, an eligible Dependent includes:

1. an eligible Employee's lawful spouse, including a spouse or former spouse for whom the Employee has received a court order to maintain financial responsibility for providing health insurance; or a **Registered Domestic Partner**; and/or
2. any unmarried child of an eligible Employee who is within the age limits set forth in the Schedule of Benefits, and is not in active military service, including:
 - a. the Employee's natural child; or
 - b. the Employee's legally adopted child;
 - c. the Employee's stepchild; or
 - d. a child for whom the Employee has received a court order to maintain financial responsibility for providing health insurance.

Eligibility will continue past the limiting age for eligible Dependent children who are primarily dependent upon the Employee for support and who cannot work to support themselves due to a physical or mental incapacity which began before the age limit was reached. Proof of such incapacity must be provided to Us upon request.

A person cannot be covered as an Employee and also as a Dependent under the Plan. If both the husband and the wife are covered as Employees under the Plan, only one may enroll for dental coverage on Dependent child(ren).

Eligibility Date

The Eligibility Date is the date a person becomes eligible to be covered under the Plan, as follows:

1. For an Employee hired after the Effective Date, the date the Employee completes the waiting period (i.e. the number of days of continuous employment required by the Plan Administrator for coverage under the Plan).
2. For an Employee hired prior to the Effective Date, the Eligibility Date will be the Effective Date. The waiting period will be waived unless indicated in the Application.
3. For a Dependent who meets the definition of an Eligible Dependent on the Employee's Eligibility Date, the Employee's Eligibility Date.
4. For a Dependent of an eligible Employee acquired while he is covered under the Plan, the date the Employee acquires the Dependent, as follows:
 - a. the date of marriage,
 - b. the date of birth,
 - c. the date of placement for adoption;

- d. the date of issuance of a court order requiring the Employee to maintain financial responsibility for health coverage for a Dependent spouse or child.

INITIAL ENROLLMENT

Effective Date

The effective date is the date coverage for a Participant actually begins. It may be different from the Eligibility Date.

Non-Contributory Coverage

Noncontributory benefits under the Plan will become effective for an Employee who is Actively at Work on the day following completion of the waiting period, if any, set forth in the Application.

Contributory Coverage

Contributory coverage will become effective as follows, provided the Employee is Actively at Work on that date:

1. If the enrollment form is signed on or before the end of the waiting period, if any, as stated in the Application, the coverage will become effective on the day following completion of the waiting period.
2. If the enrollment form is signed after the end of the waiting period, but within 31 days after that day, the coverage will become effective the date the Employee signs the enrollment form.

Dependent Coverage

Covered Employees may add Dependent children at any time, up to age 5, and coverage will become effective on the first of the month following notification to Dearborn National.

Coverage for a natural, step or adopted Dependent child who becomes eligible after the Employee's coverage effective date is automatically effective on the Dependent's Eligibility Date for 31 days. To continue coverage beyond the 31 day period, the Employee must submit application and any applicable premium within the 31 day period.

Covered Employees may add a newly acquired Dependent spouse, and if the application is received by Dearborn National within 31 days of the Dependent's Eligibility Date, the coverage will become effective on the Dependent's Eligibility Date.

Deferred Effective Date

An Employee must be Actively at Work on the date his coverage under the Plan is scheduled to begin. If:

1. he is absent from Active Work on the date such coverage would otherwise become effective; and
2. his absence is caused by an injury, illness or layoff,

the effective date of coverage will be deferred until the first day he returns to Active Work. An Employee will be considered Actively at Work if he was actually at work on the day immediately preceding:

1. a weekend (except for one or both of these days if they are scheduled work days);
2. a holiday (except when such holiday is a scheduled work day);
3. a paid vacation;
4. any nonscheduled work day.

ANNUAL ENROLLMENT

If You are eligible, and you did not enroll within 31 days of becoming eligible, You may enroll for dental coverage, or request changes to Your current dental benefits only during Annual Enrollment.

ENROLLMENT CHANGES

You should notify the Plan Administrator promptly if any of the following events take place:

1. You marry or divorce,
2. A child is acquired, by marriage, new birth or adoption,
3. A child marries or reaches the age limit described below,
4. A Participant in Your family dies, or
5. You receive a court order to provide health coverage for Your child or spouse.

You should promptly notify Dearborn National by filling out a form which has been furnished to the Plan Administrator. If You are adding a Dependent, You must submit an application and the coverage will become effective as described in the Dependent Coverage effective date provision above.

WHEN DOES COVERAGE END?

Dearborn National is not required to give You notice of termination of coverage. Dearborn National will not always know of the events causing termination until after the events have occurred.

Termination of Coverage

Coverage will end for You on the earliest of:

1. the date You are no longer a member of a covered class; or
2. the date the Plan is canceled; or
3. the effective date of an amendment to this Plan which terminates coverage for the class to which You belong; or
4. the date You stop making any required contribution toward payment of premiums; or
5. the date You are no longer Actively at Work; and
6. for Dependents, the date a Dependent child or spouse is no longer eligible for coverage as defined in this SPD.

If coverage for a Dependent terminates because of loss of eligibility as listed above, coverage ends automatically and benefits for expenses incurred after termination are not available. If we pay benefits prior to our receiving notification of your termination, We will request a refund. If your coverage or that of Your Dependents ends, You may be eligible to continue coverage at Your own expense. Review carefully the **CONTINUATION OF COVERAGE RIGHTS UNDER COBRA** Notice at the back of this SPD.

Termination of the Group

The coverage of all Participants will terminate in accordance with the terms of the Plan if the group is terminated.

LOSS OF ELIGIBILITY

If Your coverage ends due to loss of eligibility, You must meet all the requirements of a new Employee if You are rehired at a later date.

HOW THE PLAN WORKS

CHOICE OF PROVIDER

Dearborn National has an arrangement with certain Preferred Providers to discount their charges for Covered Dental Services. You have the option of selecting a Preferred Provider or a non-Preferred Provider. By choosing a Dental Network of America Dentist, Your out-of-pocket expenses are generally less than the amount owed if Non-Preferred Providers had been used.

When You receive care from a Preferred Provider:

1. confirm the Dentist's continued Dental Network of America PPO Network participation at each visit;
2. Your Dentist is responsible for submitting Your claim to Dearborn National. You do not need to submit claims for Covered Dental Services; and
3. you are not responsible for charges that exceed the Allowable Amount.

You are responsible for:

1. any Deductibles;
2. any amounts in excess of maximums;
3. Coinsurance Amounts; and
4. services that are limited or not covered by the Plan.

If Your Dentist is not a Preferred Provider, You may be responsible for filing Your claim, as described in **CLAIMS FILING PROCEDURES, Who Files Claims** subsection, and for payment in full at the time services are rendered.

CLAIM FILING PROCEDURES

Filing of Claims

All claims for benefits under this Plan must be properly submitted within 90 days of the date You receive the services or supplies. Claims not submitted and received by Dearborn National within 12 months after the date You receive the services or supplies will not be considered for payment of benefits except in the absence of legal capacity.

A claim will be considered received by Dearborn National for processing upon actual delivery to the Dearborn National Administrative Office in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied, or Dearborn National may contact either You or the Dentist for the additional information.

Who Files Claims

Provider -filed claims

Preferred Providers are responsible for submitting Your claims directly to Dearborn National for services provided to You or any of Your covered Dependents. To assist Dentists in filing Your claims, You should carry Your Identification Card with You.

Participant-filed claims

If Your Dentist is not a Preferred Provider, You may need to submit Your claim to Dearborn National using a form provided by Dearborn National. The Plan Administrator should have a supply of dental claim forms. It is important to file each Participant's expenses separately because Deductibles, maximum benefits, and other provisions are applied for each Participant separately.

Include itemized bills from the Dentist printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

Who Receives Payment

Benefit payments will be made directly to the Dentists when they bill Dearborn National. Written agreements between Dental Network of America and some Dentists may require payment directly to them, even if You file the claim. Any benefits payable to You, if unpaid at Your death, will be paid to Your beneficiary or to Your estate if no beneficiary is named.

Except as provided in the section **ASSIGNMENT AND PAYMENT OF BENEFITS**, rights and benefits under this Plan shall not be assignable, either before or after services and supplies are provided.

Benefits for services provided to Your minor Dependent child may be paid to a third party if:

1. the third party is named in a court order as managing or possessory conservator of the child; and
2. Dearborn National has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to Dearborn National, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator or guardian of the estate of the child.

Dearborn National may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to You or Your Dentist, or deduction by Dearborn National from benefit payments of amounts owed to Dearborn National will be considered in satisfaction of its obligations to You under this Plan.

An *Explanation of Benefits* summary is sent to You so You will know what has been paid.

Review of Claim Determinations

Claim Determinations

When Dearborn National receives a properly submitted claim, the Plan Administrator has delegated authority and discretion under the Plan to interpret and determine benefits in accordance with the Plan provisions. Dearborn National will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If Dearborn National requires further information in order to process the claim, we will request it within that 30-day period.

If a Claim Is Denied or Not Paid in Full

On occasion, Dearborn National may deny all or part of Your claim. There are a number of reasons why this may happen. First, read the *Explanation of Benefits* summary prepared by Dearborn National; then, review this SPD to see whether You understand the reason for the determination. If You have additional information that You believe could change the decision, send it to Dearborn National and request a review of the decision. Include Your full name, group and subscriber numbers with the request. If the claim is denied in whole or in part, You will receive a written notice, from Dearborn National with the following information, if applicable:

1. the reasons for denial;
2. a reference to the dental care plan provision on which the denial is based;
3. a description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
4. an explanation of how You may have the claim reviewed by Dearborn National if You do not agree with the denial.

Right to Review Claim Determinations

The Plan provides for two levels of appeal for all benefits. In order for a claimant to pursue his rights as explained in the "Rights After Appeal" section below, he must first exhaust his appeal rights under the Plan.

The claimant and/or his authorized representative may inspect or request, free of charge, relevant documents and submit written comments, documents, records, and other information to the Claims Administrator for review of his claim. The review of the claimant's appeal shall be reviewed without affording deference to the initial adverse benefit determination and will not be conducted by the individual who made the initial review, nor a subordinate of such individual, but shall be conducted by such individual(s) designated or appointed by the Claims Administrator.

If the claim is denied upon review and notice of such denial upon review is provided to the claimant as provided in these procedures, the claimant may pursue his rights as set h in the “Rights After Appeal” section described below.

Procedures Applicable to Appeal

If a decision is based in whole or part on a medical judgment, the appropriate person(s) determining the appeal shall consult with a healthcare professional (not consulted in the initial claim that is being appealed nor a subordinate of such healthcare professional) who has appropriate training and experience in the field of medicine involved in the medical judgment and shall provide the claimant with such information regarding such health care professionals as the Claims Administrator determines is appropriate. The claimant shall be provided with the identification of medical or vocational experts who were consulted for the appeal, without regard to whether the Claims Administrator relied upon the expert’s advice.

Notification of Decision on Review. The Claims Administrator will notify the claimant of its decision. If an expedited method such as oral notification is used, it must be followed up with a transmission of the Claims Administrator’s decision. Notifications will be set h in a manner calculated to be understood by the claimant and will contain: (i) the specific reason or reasons for the denial, (ii) specific references to Plan provisions on which the benefit determination is based, (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all material and required information relevant to the claim for benefits, (iv) a statement describing any voluntary appeals offered by the Plan, including information concerning the procedures of the voluntary appeal that would allow the claimant to make an informed decision about whether to appeal and such other information which the Claims Administrator determines is appropriate regarding alternative dispute resolution options, (v) a statement of the claimant’s right to bring an action under section 502(a) of ERISA, (vi) a description of the Protocols, if any, used to make the decision and that a copy of the Protocols will be available free of charge upon request, (vii) a statement that an explanation of the clinical and scientific judgment used in making the determination will be available free of charge upon request by the claimant, and (viii) the statement:

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and State insurance regulatory agency.

Response Dates on Appeal

For concurrent claims, the decision on review will be made before the concurrent claim benefit is reduced or terminated.

For a post-service claim, the decision on review will be made within thirty (30) days after the request for review is received by the Claims Administrator.

Written or Electronic Notifications

All notifications regarding claim decisions shall be either written or electronic. Electronic notification shall comply with standards imposed by the Claims Administrator consistent with applicable guidance.

Level Two Appeal

If you are dissatisfied with the level one appeal decision, you may request a second review. All second level mandatory appeals for pre-service, post service and concurrent care claims will be handled by your Employer. To initiate a level two appeal, you must notify your Plan Administrator in writing within 180 days of your receipt of Dearborn National’s level one appeal denial.

All second level mandatory appeals for pre-service, post service and concurrent care claims should be mailed to:
City of Columbia, Missouri
Attn: Plan Administrator, Dental Plan Appeal
600 E. Broadway, Howard Building
Columbia, MO 65201

Your Plan Administrator will forward all requests for a second review to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Dearborn National or any of its affiliates or by your Employer. A decision to use this level of appeal will not affect the claimant's rights to any other benefits under the dental plan.

Dearborn National, to the extent reasonably requested by the Plan Administrator will provide information that it has in its possession to assist the Independent Review Organization in making a second level determination.

For level two appeals, your Employer will acknowledge in writing that your request has been received and that it has been forwarded to the Independent Review Organization.

When the Independent Review Organization reaches a decision, your Employer will respond in writing to you and to Dearborn National with the decision within 15 calendar days after an appeal is received for a required Pre-Service or Concurrent Care coverage determination, and within 30 calendar days after an appeal for a Post-Service coverage determination is received.

If more time or information is needed to make the determination, your Employer will notify you in writing to request an extension of up to 15 calendar days and specify any additional information needed to complete the review.

There is no charge for you to initiate this second level appeal process. Dearborn National and your Employer will abide by the decision of the Independent Review Organization.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Doctor would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing hospital stay. When an appeal is expedited, your Employer will respond orally with a decision within 72 hours, followed up in writing to you and to Dearborn National

Rights After Appeal

If the Participant is dissatisfied with the Claims Administrator's review of the decision, the Participant has the right to file suit in a federal or state court, which suit must be filed within twelve (12) calendar months immediately following the date of such Claims Administrator's decision. No action may be brought for benefits provided by the Plan or to enforce any right hereunder until after a claim has been submitted to and determined by the Claims Administrator and all appeal rights under the Plan have been exhausted. The Participant's beneficiary should follow the same claims procedure in the event of the Participant's death.

Interpretation of the Plan Administrator's Plan Provisions-

The primary responsibility for the general administration of the Plan is placed with the Plan Administrator. However, the Claims Administrator (Dearborn National) is responsible for claims processing. Dearborn National has the delegated authority from the Plan Administrator to make all determinations concerning eligibility for coverage and benefits under the Plan. The Plan Administrator, or Dearborn National, as appropriate, in its sole discretion, shall have the power to make reasonable rules and regulations to make all determinations necessary for

the Plan's administration and to interpret the terms of the Plan. Their good faith determinations and interpretations shall be binding and conclusive on all persons.

DENTAL BENEFITS PROVIDED

Benefits are payable for Covered Dental Services and supplies that are considered Dentally Necessary. The benefit percentage to be applied to each benefit category is shown on the Schedule of Benefits.

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

HOW BENEFITS ARE CALCULATED

Benefits are paid based on the Coinsurance Amount percentage shown on the Schedule of Benefits for each category as it is applied to the Allowable Amount. To determine benefits, the Deductible (if not previously satisfied) is subtracted from the Allowable Amount for a category. This amount is then multiplied by the Coinsurance Amount percentage for that category. The resulting total is the benefit payable by Dearborn National.

The remaining unpaid amounts, including any excess portion above the Allowable Amount, any Deductible and the Coinsurance Amount percentage will be Your responsibility to pay to Your Dentist.

DEDUCTIBLE

The Deductible shown on the Schedule of Benefits will be subtracted once during each Calendar Year from the total eligible Covered Dental Services incurred for that Calendar Year. It will apply to each benefit category, unless the Schedule of Benefits indicates it is waived for a particular benefit category. It will apply to each Participant. The following exceptions will apply:

1. when any number of family Participants have satisfied the Family Deductible for a Calendar Year, any other Participants under Your coverage will not have to satisfy a Deductible for that Calendar Year.

ALLOWABLE AMOUNT DETERMINATION

In determining the Allowable Amount, Dearborn National will consider such factors as Your Dentist's usual fee and fees charged by other Dentists in the area with similar training and experience and any special circumstances. The portion of the charges by Your Dentist that exceeds the Allowable Amount will be Your responsibility to pay to Your Dentist. In other words, a certain amount of the Dentist's charge may not be considered by Dearborn National for benefits. Refer to the **DEFINITIONS** section for a detailed explanation of Allowable Amount.

CURRENT DENTAL TERMINOLOGY (CDT)

The most recent edition of the manual published by the American Dental Association (ADA) entitled Current Dental Terminology and Procedure Codes (CDT) is used when classifying dental services.

The Allowable Amount for a Covered Dental Service will be based on the most inclusive procedure codes.

COURSE OF TREATMENT

Your Dentist may decide on a planned series of dental procedures which a dental exam shows You need. In cases where there is more than one professionally acceptable Course of Treatment, benefits will be covered for the most economical procedures.

PREDETERMINATION OF BENEFITS

The Schedule of Benefits may indicate a "Predetermination Amount." If a Course of Treatment for non-emergency services can reasonably be expected to involve Covered Dental Services in excess of this predetermination amount, a description of the procedures to be performed and an estimate of the Dentist's charge should be filed with and predetermined by Dearborn National prior to the commencement of treatment.

Dearborn National may request copies of existing x-rays, photographs, models, and any other records used by the Dentist in developing the Course of Treatment. Dearborn National will review the reports and materials, taking into consideration alternative Courses of Treatment. Dearborn National will notify You and the Dentist of the benefits to be provided under the Plan. Predetermination gives You and Your Dentist the opportunity to know the extent of the benefits available. Benefit payments may be reduced based on any claims paid after a predetermination estimate is provided.

MAXIMUM BENEFITS

Maximum Calendar Year Benefits

The maximum amount of benefits available for all combined Covered Dental Services for a Calendar Year for any one Participant is the amount shown on the Schedule of Benefits.

Depending on the terms of the Plan, it may also include any benefits provided under the Plan Administrator's dental plan with another carrier prior to the Participant's effective date of coverage under this Plan.

Maximum Lifetime Benefits

The maximum lifetime benefits available for any one Participant for Orthodontic, Implant or Temporomandibular Joint (TMJ) Services is the amount shown on the Schedule of Benefits if applicable to Your coverage. Maximum lifetime benefit amounts do not apply to any other Covered Dental Services.

Depending on the terms of the Plan, it may also include any benefits provided under the Plan Administrator's dental plan with another carrier prior to the Participant's effective date of coverage under this Plan.

CHANGES IN BENEFITS

Changes in benefits will apply to all services provided to each Participant under this Plan.

Benefits for Covered Dental Services incurred during a Course of Treatment which begins before the change will be the benefits in effect on the date the Course of Treatment was started.

COVERED DENTAL SERVICES

The Plan will provide benefits for the following Covered Dental Services, subject to the limitations and Exclusions described in this SPD. **You are covered only for those benefit categories shown on the Schedule of Benefits.** The benefit percentage applicable to each benefit category is shown on the Schedule of Benefits.

The Listing of Covered Dental Services is a complete list of Covered Dental Services. We will not pay benefits for expenses incurred for any service not listed below, unless We agree to accept an unlisted service as a Covered Dental Service. We will not accept any unlisted service which is not similar to, or which does not accomplish a result similar to, a listed service. The choice of whether or not to accept an unlisted service is solely Ours. If We do accept an unlisted service as a Covered Dental Service, benefits will be payable on a basis consistent with benefits for similar Covered Dental Services which would provide the least costly adequate treatment of a Participant's dental condition according to broadly accepted standards of professional dental care as determined by Us.

Diagnostic and Preventive Care

Services that are used to prevent dental disease or to determine the nature or cause of a dental disease:

- a. Routine oral evaluations (limited to two per Calendar Year).
- b. X-rays (dental radiographs):
 - i. full mouth or panorex x-ray limited to once every 36 months;
 - ii. bitewing limited to 4 horizontal films or 8 vertical films once per Calendar Year; and
 - iii. other x-rays as necessary for diagnosis (except in connection with a program of orthodontics).
- c. Professional cleaning, scaling and polishing teeth (prophylaxis) limited to two per Calendar Year.
- d. Fluoride treatment (topical application), limited to two per Calendar Year for Participants up to age 19.

Miscellaneous Services

- a. Sealants, limited to one per un-restored permanent molar in a consecutive 36 months for Participants up to age 16.
- b. Space maintainers for Participants up to age 16.
- c. Pulp vitality tests.

- d. Palliative (emergency) treatment to relieve dental pain except when performed in conjunction with definitive dental treatment.
- e. Occlusal guards limited to one guard every consecutive 36 months

Restorative Services

The process of replacing, by artificial means, a part of a tooth that has been damaged by disease (e.g. cavities). Tooth preparation, all adhesive (including amalgam bonding agents), liners and bases are included as part of the restoration.

- a. Amalgam restorations limited to once per surface per tooth in any Calendar Year.
- b. Pin retention, per tooth, in conjunction with the restoration.
- c. Composite restorations limited to once per surface per tooth per Calendar Year.
- d. Simple tooth extraction.

General Services

- a. Intravenous sedation.
- b. General Anesthesia.
- c. House call.
- d. Injection of Antibiotic drugs.
- e. Stainless steel crowns limited to one per tooth in a 60 month period and not to be used as a temporary crown.

Endodontic Services

Dental Services for prevention, diagnosis and treatment of diseases and injuries affecting the tooth and dental pulp.

- a. Root canal therapy including treatment plan, clinical procedures, pre and post-operative radiographs and follow-up care.
- b. Direct pulp cap.
- c. Apicoectomy/periradicular services.
- d. Apexification/recalcification.
- e. Retrograde filling.
- f. Root amputation/hemisection.
- g. Therapeutic pulpotomy.
- h. Gross pulpal debridement.

Periodontal Services

Dental Services that treat diseases of the tissues that surround and support the teeth (e.g. gums and supporting bone) limited to two exams per Calendar Year. Periodontal maintenance includes the following:

- a. Periodontal scaling and root planning limited to one time per quadrant per Calendar Year;
- b. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to one time per Calendar Year;
- c. Gingivectomy or gingivoplasty limited to one time per quadrant per Calendar Year;
- d. Gingival flap procedure (includes root planning) limited to one time per quadrant per Calendar Year;
- e. Osseous surgery, including flap entry with closure limited to one time per quadrant per Calendar Year;
- f. Osseous grafts limited to one time per site per Calendar Year; and

- g. Soft tissue grafts (includes donor site).

Oral Surgery Services

Dental Services for the treatment of certain dental conditions by operative or cutting procedures.

- a. Surgical tooth extractions.
- b. Alveoloplasty.
- c. Vestibuloplasty.
- d. Other Dentally Necessary surgical procedures.

Crowns, Inlays/Onlays Services

Dental services resulting from extensive disease or fracture limited to one per tooth in a 60 month period.

- a. Prefabricated post and cores.
- b. Cast post and cores.
- c. Crown, inlays/onlays repairs
- d. Recementation of inlays/onlays, crowns.

Benefits include the replacement of a lost or defective crown whether placement was under this Plan or under any prior dental coverage and even if the original crown was stainless steel.

Benefits will not be provided for replacement of dentures, crowns, inlays/onlays, removable or fixed prostheses, and dental restorations due to theft, misplacement, or loss; or for replacement of dentures, removable or fixed prostheses, and dental restorations for any other reason within 60 months after receiving such dentures, prostheses, or restorations.

Prosthodontic Services

Dental services that restore and maintain the oral function, comfort and health of a patient by replacing missing teeth and surrounding tissue with artificial substitute. Covered Services include bridges, partial dentures and complete dentures.

- a. Initial installation of bridgework (including inlays and crowns as abutments) limited to once per tooth in any 60 month period, whether placement was under this Plan or under any prior dental coverage.
 - i. Bridge repair.
 - ii. Recementing a bridge.
 - iii. Post and core buildup.
- b. Initial installation of removable complete, immediate or partial dentures (including any adjustments, relines or rebases during the 6 month period following installation) limited to once in any 60 month period, whether placement was under this Plan or under any prior dental coverage.

Benefits are available for the replacement of complete or partial dentures, but only if the appliance is 60 months old or older and cannot be made serviceable.
- c. Adjustments limited to 3 times per appliance in any Calendar Year.
- d. Repairs.
- e. Addition of tooth or clasp (unless additions are completed on the same date as replacement partials/dentures) limited to a lifetime maximum of once per tooth.
- f. Denture rebase and reline procedures limited to one in any 36 month period.

EXCLUSIONS

*In addition to those benefit maximums and limitations described in **DENTAL BENEFITS PROVIDED**, the benefits of the Plan are not available for any Covered Dental Services incurred:*

1. In connection with an occupational illness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
2. For which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for dental assistance (Medicaid); provided, however, this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
3. As a result of disease contracted or injuries sustained as a result of war, declared or undeclared, or any act of war.
4. Primarily for cosmetic purposes, including but not limited to bleaching teeth, grafts to improve esthetics, except for:
 - a. Services provided for correction of defects incurred through traumatic injuries sustained by the Participant while covered under the Plan; or
 - b. Covered orthodontic diagnostic procedures and treatment; or
 - c. Services provided to a newborn child which are necessary for treatment or correction of congenital defects.
5. For services or supplies which do not meet accepted standards of dental practices.
6. For services provided or received for:
 - a. behavior management; or
 - b. consultation purposes.
7. For Benefits for an alternate Course of Treatment which exceeds the most economical procedures.
8. For personalized complete or partial dentures, overdentures, and their related procedures, or other specialized techniques not normally taught in regular dental school classes; for services or supplies which do not meet accepted standards of dental practice, including charges for services or supplies which are Experimental/Investigational in nature or not fully approved by a Council of the America Dental Association; and for services or supplies not Dentally Necessary.
9. For treatment provided before the effective date of a Participant's coverage or after termination of coverage under this Plan.
10. For appliances, materials, restorations, or special equipment used to increase vertical dimension, correct or restore the occlusion except as may be provided on the Schedule of Benefits.
11. To correct temporomandibular joint (TMJ) dysfunction or pain syndromes except as may be provided on the Schedule of Benefits.
12. For which benefits are otherwise provided under inpatient hospital expense or medical-surgical expense coverage under the medical benefits of the health benefit plan.
13. For treatment by other than a Dentist, except that x-rays, scaling, cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist, if the treatment is provided under the supervision and guidance of the Dentist.
14. For replacement or repair of an orthodontic appliance.

15. For services or supplies when:
 - a. no charge is made;
 - b. the Participant is not legally obligated to pay;
 - c. no charge would be made in the absence of this or similar dental coverage;
 - d. “discounts” or waiver of a Deductible or Coinsurance Amounts are offered;
 - e. treatment is received by a Dentist who is related to the Participant by blood or marriage; or
 - f. treatment is provided through a medical department, clinic, or similar facility furnished or maintained by the Plan Administrator.
16. For a duplicate prosthetic device, other duplicate appliances or duplicate dental restoration.
17. For:
 - a. dietary and oral hygiene instruction, a plaque control program and tobacco use counseling; and
 - b. For prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
18. For any charge:
 - a. Resulting from the failure of a Participant to keep a scheduled visit with a Dentist; or
 - b. For completion of any insurance forms; or
 - c. For telephone consultations; or
 - d. For records or x-rays necessary for Dearborn National to make a benefit determination.
19. For splinting, grafting and preparation associated with Implants, if “Implants” is not indicated on Your Schedule of Benefits.
20. For splinting of teeth, including double abutments for prosthetic abutments.
21. For Accidental Injuries including tooth transplantation.
22. For pin retention **not** performed on the same date of service and in conjunction with a covered amalgam or composite restoration.
23. For administration of any local anesthesia, and necessary infection control as required by OSHA, state and federal mandates billed separately.
24. For palliative (emergency) treatment performed in conjunction with definitive dental treatment.
25. For indirect pulp capping.
26. For athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/ malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
27. For bacteriological studies for determination of pathologic agents and soft tissue allograft.
28. For biologic materials, cytology sample collection and histopathological examinations.
29. For canal preparation and fitting of prefabricated dowel and post if billed separately.
30. For caries susceptibility tests.
31. For chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy.
32. For crowns to restore occlusion or incisal edges due to bruxism or harmful habits.
33. For desensitizing medicaments and/or their application.

DEFINITIONS

This section tells You the meaning of special words and phrases used in this SPD. To help You recognize these special words and phrases, the first letter of each word, or each word in the phrase, is capitalized wherever it appears.

Actively at Work means that You are:

1. performing the normal duties of Your occupation; and
2. working the number of hours set h in the Application.

Allowable Amount means the maximum amount determined by Dearborn National to be payable for a particular service, supply, or procedure. To calculate the Allowable Amount, Dearborn National uses the most appropriate method in consideration of the Dentist and/or type of service as follows:

1. For Preferred Providers, the Allowable Amount is the lesser of:
 - a. the Maximum Allowance for the service or, supply or procedure; and
 - b. the amount charged by the Preferred Provider for the service, procedure or supply.
2. For non-Preferred Providers, the Allowable Amount is the lesser of:
 - a. The Reasonable and Customary Charge for the service or supply; and
 - b. the amount charged by the provider for the service or supply

Unless otherwise stipulated by a contract between the Dentist and carrier:

1. an Allowable Amount will be established by identifying Dentists with similar experience or skill in order to establish the applicable amount for the procedure, services, or supplies.
2. for multiple surgical procedures performed in the same operative area, the Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.
3. when a less expensive professionally acceptable service, supply, or procedure is available, the Allowable Amount will be based upon the least expensive service. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

The Allowable Amount for all Covered Dental Services also includes the administration of any local anesthesia and necessary infection control as required by state and federal mandates.

Annual Enrollment means the 31-day period preceding the next period during which Employees and Dependents may enroll for coverage.

Application means the document which sets h the relevant information pertaining to the Plan. The Application is attached to and forms a part of the Plan and this SPD, and shall include any subsequent amendments to the Application.

Calendar Year means the period commencing each January 1 and ending on the next succeeding December 31, inclusive.

Claims Administrator means Dearborn National Insurance Company .

Coinsurance Amount means the dollar amount of Covered Dental services eligible for benefits that are incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

Course of Treatment means any number of dental procedures or treatments performed by a Dentist in a planned series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

Covered Dental Services means the professionally recognized dental services, supplies, or appliances for which a benefit is available to a Participant when provided by a Dentist on or after the Effective Date of coverage and for which the Participant acquires an obligation for payment.

Deductible means the dollar amount of Covered Dental Services that must be incurred by a Participant before benefits under the Plan will be available.

Dentally Necessary or **Dental Necessity** means those services, supplies, or appliances covered under the Plan which are:

1. essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
2. provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. not primarily for the convenience of the Participant or his Dentist; and
4. the most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

Dearborn National shall determine whether a service, supply, or appliance is Dentally Necessary and will consider the views of the state and national health communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Dentist may have prescribed treatment, such treatment may not be Dentally Necessary within this definition.

Dentist means a person, when acting within the scope of his license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy.

Eligibility Date means the date the Participant satisfies the definition of either Employee or Dependent or Retiree and is in a class eligible for coverage under the Plan as described in **WHO GETS BENEFITS**.

Employee or Eligible Employee means an Actively at Work full-time employee whose principal employment is with the Employer at the Employer's usual place of business or such place(s) that the Employer's normal course of business may require, who is Actively at Work for at least the number of hours per week as stated in the Application and is reported on the Employer's records for Social Security and withholding tax purposes.

Employer means, in addition to the person, firm, or institution named on the cover of this SPD, one or more subsidiaries or affiliates, if any.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment. *Standard medical treatment* means the services or supplies that are in general use in the medical community in the United States, and:

1. have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
2. are appropriate for the hospital or facility in which they were performed; and
3. the Dentist has had the appropriate training and experience to provide the treatment or procedure.

Dearborn National shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational within this definition.

Although a Dentist may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, Dearborn National still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as a part of a clinical trial or a research study is Experimental/ Investigational.

Maximum Allowance means the amount determined by Dearborn National which Preferred Providers have agreed to accept as payment in full for a particular Covered Dental Service. These amounts may be amended from time to time by Dearborn National.

Participant means an Employee, Dependent, or a retired Employee whose coverage has become effective under this Plan.

Plan means the group dental plan provided by the Plan Administrator

Plan Administrator means City of Columbia, Missouri

Preferred Provider means a dentist, dental hygienist, dental office or medical center or any dental care provider who is a participant in Dearborn National's Preferred Provider plan.

Proof of Loss means written evidence of a claim including:

1. the form on which the claim is made;
2. bills and statements reflecting dental services, supplies, and appliances furnished to a Participant and amounts charged for those services, supplies, and appliances that are covered by the claim; and
3. correct diagnosis and procedure code(s) for the services and items.

Reasonable and Customary means charges made for services or supplies essential to the care of the individual. Charges will be considered reasonable and customary if they are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are reasonable and customary.

Registered Domestic Partner means an adult of the same or opposite gender who has an emotional, physical and financial relationship to **You**, similar to that of a Spouse, as evidenced by the following:

1. **You** and **Your Domestic Partner** share financial responsibility for a joint household and intend to continue an exclusive relationship indefinitely;
2. **You** and **Your Domestic Partner** each are at least eighteen (18) years of age;
3. **You** and **Your Domestic Partner** are both mentally competent to enter into a binding contract;
4. **You** and **Your Domestic Partner** share a residence and have done so for at least 12 months;
5. Neither **You** nor **Your Domestic Partner** are married to or legally separated from anyone else;
6. **You** and **Your Domestic Partner** are not related to one another by blood closer than would bar marriage; and
7. Neither **You** nor **Your Domestic Partner** is a **Domestic Partner** of anyone else.

You or Your means the Employee to whom this SPD has been delivered.

We, Our, Us means Dearborn National Insurance Company.

GENERAL INFORMATION

PARTICIPANT/DENTIST RELATIONSHIP

The choice of a Dentist is made solely by a Participant. Dearborn National does not furnish services but only makes payment for Covered Dental Services incurred by Participants. Dearborn National is not liable for any act or omission by any Dentist and Dearborn National does not have any responsibility for a Dentist's failure or refusal to provide services to a Participant.

ASSIGNMENT AND PAYMENT OF BENEFITS

If a written assignment of benefits is made by a Participant to a Preferred Provider and the written assignment is delivered to Dearborn National with the claim for benefits, Dearborn National will make any payment directly to the Preferred Provider. Payment to the Preferred Provider discharges Dearborn National's responsibility to the Participant for any benefits available under the Plan.

REFUND OF BENEFIT PAYMENTS

If Dearborn National pays benefits for Covered Dental Services incurred by You or Your covered Dependents and it is found that the payment was more than it should have been, or was made in error, Dearborn National has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, Dearborn National may deduct any refund due it from any future benefit payment.

COORDINATION OF BENEFITS

The availability of benefits specified in this Plan is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has dental coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:
 - a. group or blanket insurance;
 - b. franchise insurance that terminates upon cessation of employment;
 - c. group dental service plans and other group prepayment coverage;
 - d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
 - e. governmental plans, or coverage required or provided by law.

Plan does not include:

- a. any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- b. a policy of dental insurance that is individually underwritten and individually issued;
- c. school accident type coverage; or
- d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each Policy or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **This Plan** means the City of Columbia, Missouri dental benefit plan.

3. **Primary Plan/Secondary Plan**

The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for dental care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.

5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

6. **We or Us** means Dearborn National Insurance Company or Dearborn National.

Order of Benefit Determination Rules

1. **General Information**

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless

- a. the other Plan has rules coordinating its benefits with those of This Plan, and
- b. both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

2. **Rules**

This Plan determines its order of benefits using the first of the following rules which applies:

- a. **Non-Dependent/Dependent** – The benefits of the Plan which covers the Participant as an Employee, member, or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - i. secondary to the Plan covering the Participant as a Dependent; and
 - ii. primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.
- b. **Dependent Child/Parents Not Separated or Divorced** – Except as stated in paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:
 - i. The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
 - ii. If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in this paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- c. ***Dependent Child/Parents Separated or Divorced*** – If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - i. First, the Plan of the parent with custody of the child;
 - ii. Then, the Plan of the spouse of the parent with custody, if applicable;
 - iii. Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the dental care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph c does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. ***Joint Custody*** – If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in paragraph b.
- e. ***Active/Inactive Employee*** – The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph e does not apply.
- f. ***Continuation Coverage*** – If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:
 - i. First, the benefits of a Plan covering the Participant as an Employee, member, or subscriber (or as that Participant's Dependent);
 - ii. Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph f does not apply.
- g. ***Longer/Shorter Length of Coverage*** – If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of this Plan

1. *When This Section Applies*

This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. *Reduction in this Plan's Benefits*

- a. The benefits of This Plan will be reduced when the sum of:
 - i. the benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
 - ii. the benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.
- b. If This Plan is a Secondary Plan, the total Allowable Expenses incurred for a Covered Person in any Claim Determination Period are the lessor of:
 - i. the benefits that would be payable under This Plan without applying the Coordination of Benefits Provision; and

- ii. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information We need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give Us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

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

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons we have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Dentists; or
4. any other person or organization.

**INFORMATION CONCERNING EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974
(ERISA)**

If the Plan is part of an “employee welfare benefit plan” and “welfare plan” as those terms are defined in ERISA, the responsibilities of the Plan Administrator, You, and Dearborn National include the following:

1. the Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to You and other plan participants and to the government as required by ERISA and its regulations.
2. Upon written request by the Plan Administrator, Dearborn National will send any information which Dearborn National has that will aid the Plan Administrator in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of the Plan. Claim filing and claim review procedures are found in the **DENTAL BENEFITS PROVIDED** section of this SPD.
4. Dearborn National is not the ERISA “plan administrator” for benefits or activities pertaining to the Plan.
5. The Plan Administrator has given Dearborn National the authority and discretion to interpret the Plan provisions and to make eligibility and benefit determinations.

AMENDMENTS

The Plan may be amended or changed from time to time by the Plan Administrator and/or Dearborn National. No notice to or consent by any Participant is necessary to amend or change the Plan.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

You are receiving this notice because You have recently become covered under Your Employer's group health **plan** (the Plan). This notice contains important information about Your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to You and to other members of Your family who are covered under the Plan when You would otherwise lose Your group health coverage. Contact Your Employer to determine if You are eligible for COBRA continuation coverage.

This notice generally explains:

- COBRA continuation coverage,
- When it may become available to You and Your family, and
- What You need to do to protect the right to receive it.

This notice gives only a summary of Your COBRA continuation coverage rights. For more information about Your rights and obligations under the Plan and under federal law, You should either contact the Plan Administrator or review the SPD or SPD of Coverage provided to You by Your Plan.

The Plan Administrator of the Plan is named by the Employer or by the group health plan. Either the Plan Administrator or a third party named by the Plan Administrator is responsible for administering COBRA continuation coverage. Contact Your Plan Administrator for the name, address, and telephone number of the party responsible for administering Your COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and Dependent children of employees may be qualified beneficiaries. Under the Plan, generally most qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Contact Your Employer and/or COBRA Administrator for specific information for Your Plan.

If You are an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee, You will become a qualified beneficiary if You will lose Your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;

3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced or legally separated from Your spouse.

Your Dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the Plan as a "Dependent child."

If the Plan provides health care coverage to retired employees, the following applies:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and Dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

The Employer must notify the Plan Administrator within 30 days when the qualifying event is:

- The end of employment;
- The reduction of hours of employment;
- The death of the employee;
- In the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer; or
- The enrollment of the employee in Medicare (Part A, Part B, or both).

For the other qualifying events (divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), You must notify the Plan Administrator. The Plan requires You to notify the Plan Administrator within 60 days after the qualifying event occurs. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage *may* last for up to 36 months when the qualifying event is:

- The death of the employee;
- The enrollment of the employee in Medicare (Part A, Part B, or both);
- Your divorce or legal separation; or
- A Dependent child losing eligibility as a Dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended.

Disability extension of 18-month period of continuation coverage

If You or anyone in Your family covered under the Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and You notify the Plan Administrator in a timely fashion, You and Your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that Your Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second qualifying event extension of 18-month period of continuation coverage

If Your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in Your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and Dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under the Plan as a Dependent child.

In all of these cases, You must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Contact Your Employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

IF YOU HAVE QUESTIONS

If You have questions about Your COBRA continuation coverage, You should contact the Plan Administrator or You may contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members You should also keep a copy, for Your records, of any notices You send to Your Plan Administrator.

SUMMARY

Name of Plan	City of Columbia, Missouri Group Dental Plan
Plan Number	
Date Established	
Type of Plan	Self Insured Benefit Plan
Plan Year	
Plan Sponsor - Employer	City of Columbia, Missouri 600 E. Broadway Howard Building Columbia, MO 65201
Employer Identification Number	43-6000810
Plan Administrator	City of Columbia, Missouri 600 E. Broadway Howard Building Columbia, MO 65201
Claim Administrator	Dearborn National 1020 31st Street Downers Grove, IL 60515-5591
Trustee	
Agent for Service of Legal Process	[To be provided by Employer]
Contributions	Employer Paid



Administrative Office:

1020 31st Street • Downers Grove, Illinois 60515-5591

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