Summary Plan Description

ERIE Indemnity Company
Health Protection Plan

Effective: January 1, 2025
Group Number: 903046

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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Claims Administrator: 1-888-651-7322.
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 740816, Atlanta, Georgia 30374-0816.
- Online assistance: **www.myuhc.com**.

Erie Insurance is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Erie Indemnity Company Health Protection Plan. 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.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It is effective as of January 1, 2025 and it supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT

A healthcare service, supply, Prescription Drug Product or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary, unless it is specifically provided that medical necessity is not required. (See definitions of Medically Necessary and Covered Health Service in Section 14, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Erie Insurance 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 SPD and the contents of the Plan, your rights shall be determined under the Plan and not under this SPD.

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 administers claims under the Plan. Although UnitedHealthcare will assist you in many ways, it does not guarantee any Benefits. Because the Plan is self-insured by Erie Insurance, Erie Insurance 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 the Benefits Operations & Planning Section of Erie Insurance or call the number on your ID card. Information provided to you by the Benefits Operations & Planning Section of Erie Insurance or by United Healthcare is for informational purposes only and is not, and should not be considered, part of the Plan.

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 a copy of the SPD and any future changes to it on Erie's intranet (ERIEweb – Info Center – Benefits Info – Benefits Summary Plan Descriptions for Employees) or request a printed copy by contacting the Benefits using ERIE's HR Helpline at 814-870-3747 or email benefits.operations@erieinsurance.com.
- 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*.
- Erie Insurance 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.
- 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 an Employer. Under the Plan you are a regular full-time Employee if (i) you are paid on a salaried basis; or (ii) are paid on an hourly basis and are regularly scheduled to work at least 37.5 hours per week in a normal work week. You are not eligible to enroll in the Plan if (i) you are a "leased employee" under the Federal tax code; (ii) you are on another company's payroll; (iii) you are treated as an independent contractor by Erie Insurance; or (iv) you are a temporary employee. If you do not fall into an eligible category listed above, you will not be eligible to enroll for coverage under the Plan as an Employee unless and until you are later classified by Erie Insurance as an eligible Employee.

You are also eligible to enroll in the Plan if you are an Eligible Retiree. You are an Eligible Retiree if you retire from an Employer after you reach age 60 provided:

- You attained age 60 by July 1, 2010; and
- You had at least 15 years of active, full-time credited service by July 1, 2010; and
- You either (i) retire as a full-time Employee under the provisions of the Erie Insurance Group Retirement Plan; or (ii) you terminate employment as a full-time Employee under long-term disability leave or work injury leave.

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 or a child placed for adoption;
- a child who is under age 26 who (i) is being solely supported by you; (ii) is not your child; and (iii) either (A) the child is related to you by blood or marriage (but is not your child or stepchild), or (B) you are the legal guardian of the child. If the child is your foster child under applicable law, the requirement that you solely support the child will be automatically treated as being satisfied; or

- an unmarried child who otherwise meets one of the criteria in the preceding two bullets, but who has attained age 26, became disabled prior to attaining age 26, is dependent on you, and who was covered under the Plan on the day he/she turned age 26.

Note: If you want to continue coverage for your disabled Dependent child, you must notify UnitedHealthcare at least 31 days before the end of the month in which your Dependent will attain age 26. You will be required to submit proof of your child's disability. See Section 12, *Coverage for a Disabled Child* for further details. If you fail to continue active (i.e. non-COBRA) coverage for your disabled Dependent upon his/her attaining age 26, or if your disabled Dependent ceases to be covered under the Plan on a later date (e.g., you drop his/her coverage during annual open enrollment) your disabled Dependent will cease to be eligible as a Dependent and you will not be able to re-enroll him/her in the Plan.

Note: You may not enroll your Dependents in the Plan unless you are also enrolled. If you and your Spouse are both eligible for coverage under the Plan as full-time Employees or as Eligible Retirees, you may each be enrolled as an Employee or Eligible Retiree or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both enrolled as full-time Employees or Eligible Retirees under the Plan, only one parent may enroll children as Dependents. In no case may anyone be enrolled as both a full-time Employee or Eligible Retiree and as a Dependent of another person.

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 Erie Insurance share in the cost of the Plan. Your contribution amount depends on the option you select (Health 1, Health 2 or CDHP) and the family members you choose to enroll. Your cost of coverage also depends on whether you are subject to the tobacco user surcharge. For more information on the tobacco surcharge, see *Tobacco Surcharge* below in this Section 2.

As an Employee, your contributions are deducted from your paychecks on either a before-tax basis under the Erie Indemnity Company Pre-Tax Payment Plan, or after-tax, depending on your election.

Erie Insurance reserves the right to prospectively change contribution rates for Employees and Eligible Retirees from time to time.

You can obtain current contribution rates by calling Benefits using ERIE's HR Helpline, (814) 870-3747, emailing benefits.operations@erieinsurance.com, or logging onto the Erie Insurance internal Intranet website at (ERIEweb – Benefits Info – Health).

Tobacco Surcharge

The Plan includes a tobacco user surcharge program. Under the tobacco user surcharge program, you will pay a surcharge of $50 per month towards the cost of coverage if you or any covered Dependent of yours is a tobacco user. This surcharge applies to active

Employees as well as to retirees. A person is a "tobacco user" if the person uses any of the following products:

- Cigarettes
- Cigars
- Pipe tobacco
- Snuff
- Tobacco chew
- E-cigarettes
- Any other tobacco product, including any smokeless tobacco product

In order not to be charged with the tobacco surcharge, you will generally be required to periodically attest, at least annually, that you and each of your covered Dependents is not a tobacco user. Generally, the attestation will require that you and any covered Dependent not use tobacco for at least the preceding 90 days.

If you are unable to attest at the beginning of a plan year (January 1st) that you and all of your covered Dependents are not tobacco users, you will be provided with the opportunity to make a new attestation in July of that plan year.

A newly enrolled Employee will make the attestation at the time of enrollment.

If you make an attestation and circumstances change (e.g. you or a covered Dependent becomes a tobacco user) you are to notify the Benefits Operations & Planning Section of Erie Insurance.

If you or a covered Dependent are a tobacco user, a reasonable alternative will be offered to each tobacco user to allow you to avoid the tobacco surcharge. The reasonable alternative will be a class, course or other program (such as a smoking cessation course) that is designed to help the tobacco user quit tobacco use. The cost of the reasonable alternative will be covered in full. The reasonable alternative will be offered to each Covered Person who is a tobacco user. Recommendations of your personal physician will be accommodated. Upon the completion of the reasonable alternative by each tobacco user, the tobacco surcharge imposed on you for the plan year (or the portion of the plan year, where the reasonable alternative was begun mid-year) will be reimbursed to you regardless of whether any Covered Person has ceased to be a tobacco user. Erie Insurance, in its sole discretion, may waive the requirement that a Covered Person who is a tobacco user complete a reasonable alternative in order to not have a tobacco user surcharge imposed.

How to Enroll

You can enroll by logging on to the Erie Insurance internal Intranet website at (ERIEweb – myBenefits) or by contacting Benefits using ERIE's HR Helpline, (814) 870-3747, or email benefits.operations@erieinsurance.com within 31 days of the date you first become eligible to enroll in coverage. If you do not enroll within 31 days, you generally 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 election. Any changes you make during Open Enrollment will become effective the following January 1.

Important
If you wish to change your election following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the Benefits Operations & Planning Section of Erie Insurance within 31 days of the event. Otherwise, you will generally need to wait until the next annual Open Enrollment to change your election.

When Coverage Begins

Once Erie Insurance receives your properly completed enrollment, your coverage will begin as follows:

- If you enroll when you are first hired as a full-time Employee, coverage begins on your date of hire.
- If you do not enroll when you are first hired as a full-time Employee, your coverage will begin the January 1st after you enroll during an Open Enrollment, or, if you enroll mid-year, in accordance with the special enrollment rules under "Changing Your Coverage Mid-Year" below.
- If your status changes from part-time Employee to full-time Employee and you enroll at that time, your coverage begins when you become a full-time Employee.

Coverage for your Dependents will begin as follows:

- If you enroll in family coverage when you first become covered under the Plan, coverage for your Dependents who you enroll will begin at the same time. If you change coverage to family coverage, coverage for any Dependents you newly enroll will begin on the effective date of the change to family coverage.
- If you enroll in employee and spouse coverage when you first become covered under the Plan, coverage for your Spouse will begin at the same time. If you change your coverage to employee and spouse coverage, coverage for your Spouse will begin on the effective date of the change to employee and spouse coverage (unless your Spouse was already covered because you changed from family coverage).
- If you enroll in employee plus children coverage when you first become covered under the Plan, coverage for your Dependent children who you enroll will begin at the same time. If you change coverage to employee plus children coverage, coverage for Dependent children who you enroll will become effective on the date of the change to employee plus children coverage (unless an enrolled Dependent child was already covered because you changed from family coverage).

In order for a Dependent to be covered under the Plan, you must enroll the Dependent in the Plan.

If you acquire a Spouse and/or Dependent stepchild through marriage and you enroll the Spouse and/or Dependent in a timely manner, coverage is effective as of the date of the marriage. If you acquire a Dependent child through birth, adoption, or placement for adoption and you enroll the Dependent child in the Plan in a timely manner, coverage is effective as of the date of birth, adoption or placement for adoption. See *Changing Coverage or Enrolled Dependents Mid-Year* below in this Section 2.

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 Coverage or Enrolled Dependents Mid-Year

Generally, you may not make changes in your coverage or enroll a Dependent during the year. However, there are certain events that give rise to special enrollment rights, allowing you to make mid-year changes. You may make coverage changes, including enrolling yourself or Dependents in the Plan, during the year only if you experience a change in status. Your 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 status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- 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 COBRA benefits through another employer's health plan, provided COBRA premiums were being paid on a timely basis;
- the death of a covered Dependent;
- your covered Dependent child no longer qualifying as an eligible Dependent (for example, because the child reaches age 26);
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- a cessation of employer contributions under another health plan (this is true even if you or your eligible Dependent continues to receive coverage under the other 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 covered 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 the Benefits Operations & Planning Section of Erie Insurance within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact the Benefits Operations & Planning Section of Erie Insurance 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 the Benefits Operations & Planning Section of Erie Insurance within 31 days of the change in status. Otherwise, you will need to wait until the next annual Open Enrollment to make changes in coverage.

You may enroll a newborn child or newly adopted child within 90 days after the date the child was born or placed for adoption with you. However, if you do not timely enroll the child within 31 days after the date the child was born or placed for adoption, coverage will only be provided from the date of enrollment.

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, coverage for the child will end when the placement ends.

Change in Status - Example
Jane is a full-time Employee who is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in the 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 through his former employer. Due to this status change, Jane can make a mid-year election of family medical coverage under the Plan even though it is outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Accessing Benefits.
- Eligible Expenses.
- Annual Deductible.
- Copayment.
- Coinsurance.
- Out-of-Pocket Limits.

Accessing Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional to provide you with 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 and who are in the Choice Plus Network. These Physicians and health care professionals are referred to as Network Physicians and Network providers.

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 Choice Plus 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 the Choice Plus Network. Providers may be in some UnitedHealthcare networks, but not all of them. Do not assume that just because a provider is, or advertises itself as, a "UnitedHealthcare network" provider that the provider is in the Choice Plus Network. It is important that you confirm the provider is in the Choice Plus Network by checking the provider directory at www.myuhc.com or by calling UnitedHealthcare at the number on your ID card. We also suggest that you confirm with your provider at the time of service that they are still a Network provider for the Choice Plus Network.

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

When Covered Health Services are provided by a Network Physician or other Network provider at a facility that is identified as a Centers of Excellence certain additional Plan benefits may be available.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that is identified by UnitedHealthcare as a Designated Provider. Only certain Physicians and providers have been identified as a Designated Provider. Designated Network Benefits are available only for specific Covered Health Services as identified in Section 5, *Plan Highlights*. When Designated Network Benefits apply, they are included in and subject to the same Annual Deductible and Out-of-Pocket Maximum requirements as all other Covered Health Services provided by Network providers.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider or by a Network facility. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a Primary Care Physician or PCP.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider (including a Specified Non-Network Provider), or Covered Health Services that are provided by a non-Network facility. In general health care terminology, non-Network Benefits may also be referred to as out-of-network Benefits.

Emergency Health Services provided by a Non-Network Emergency Facility or a Specified Non-Network Provider will be covered as described in *Eligible Expenses* at the end of this section.

Covered Health Services provided at a Specified Network Facility by a Specified Non-Network Provider, when not Emergency Health Services, will be covered as described in *Eligible Expenses* at the end of this section.

Air Ambulance transport provided by a non-Network provider will be covered as described in *Eligible Expenses (for Health 1, Health 2 and CDHP Options) - Non-Network Benefits* at the end of this section. Ground Ambulance transport provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses (for Health 1, Health 2 and CDHP Options) - Non-Network Benefits* as described at the end of this section.

Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to non-Network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of Shared Saving Program in Section 14, *Glossary*, of the SPD for details about how the Shared Savings Program applies.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under the Plan. As a result, they may bill you for the entire cost of the services you receive instead of the fee(s) they have negotiated with UnitedHealthcare.

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 may be responsible for any amount that exceeds the Eligible Expense. See *Eligible Expenses* below. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Deductible or Out-of-Pocket Limits. 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 when Covered Health Services are received from a non-Network provider. If UnitedHealthcare confirms that care is not available from a Network provider, UnitedHealthcare will work with you and your Network Physician (if you have one) to coordinate care through a non-Network provider.

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 must be in the Choice Plus Network and a provider's Network status may change. Before obtaining services you should always verify the Network status of a provider. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the number on your ID card or log onto **www.myuhc.com**. You should also confirm with your provider at the time of service that they are still a Network provider for the Choice Plus Network.

Network providers are independent practitioners and are not employees of Erie Insurance or UnitedHealthcare.

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

Do not assume that a Network provider's agreement with UnitedHealthcare includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Refer to your provider directory or contact UnitedHealthcare for assistance.

If you receive a Covered Health Service from a non-Network provider and were informed incorrectly prior to receipt of the Covered Health Service that the provider was a Network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for Network Benefits.

It is possible that you might not be able to obtain services from a particular Network provider. The Network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network

Benefits. However, if you are currently receiving treatment for Covered Health Services from a provider whose network status changes from Network to non-Network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the Network Benefit level for specified conditions and timeframes (generally, up to 90 days). This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. To be eligible for transition of care benefits, one of the following must apply: (1) You are undergoing a treatment for a Serious and Complex Condition from the provider; (2) You are undergoing a course of institutional or inpatient care from the provider; (3) You are scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider with respect to the surgery; (4) You are pregnant and undergoing a course of treatment for pregnancy from the provider; or (5) You are Terminally Ill and are receiving treatment for such illness from the provider. If you would like help to find out if you are eligible for transition of care benefits, please call the telephone number on your ID card.

The description of the transition of care benefits described in the preceding paragraph is intended to reflect the requirements of the Consolidated Appropriations Act, 2021. The transition of care benefits will be administered in compliance with applicable guidance issued under the transition of care provision of the Consolidated Appropriations Act, 2021.

Eligible Expenses (for Health 1, Health 2 and CDHP Options)

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

Eligible Expenses are the amount, determined by the Claims Administrator, on which the Plan will base its payment for Benefits. Your cost sharing (deductible and coinsurance) is also based on the Eligible Expense amount, except for the instances described below where cost-sharing is based on the Recognized Amount.

- For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, you only have to pay the applicable Copayment, Coinsurance or Deductible; you are not responsible for any difference between Eligible Expenses and the amount the provider bills.
- For Non-Network Benefits, **except as described below**, you are responsible for paying, directly to the non-Network provider, your applicable Copayment, Coinsurance or Deductible *plus* the amount the provider bills you that is greater than the amount the Claims Administrator determines to be an Eligible Expense as described below.
    - For Covered Health Services that are **Ancillary Services received at a Specified Network Facility on a non-Emergency basis from a Specified Non-Network Provider** you are not responsible, and the Specified Non-Network Provider may not bill you, for amounts in excess of your Copayment,

Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.

- For Covered Health Services that are **non-Ancillary Services received at a Specified Network Facility on a non-Emergency basis from Specified Non-Network Provider where the notice and consent criteria described below has not been satisfied**, you are not responsible, and the Specified Non-Network Provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are **non-Ancillary Services received at a Specified Network Facility on a non-Emergency basis from Specified Non-Network Provider where the notice and consent criteria described below has been satisfied,** but the Covered Health Services are the result of **unforeseen urgent medical needs** you are not responsible, and the Specified Non-Network Provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are **Emergency Health Services provided by a Non-Network Emergency Facility or a Specified Non-Network Provider**, you are not responsible, and the Non-Network Emergency Facility or Specified Non-Network Provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Services that are **Air Ambulance services provided by a non-Network provider**, you are not responsible, and the non-Network provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Deductible which is based on the rates that would apply if the Air Ambulance service was provided by a Network provider which is based on the Recognized Amount as defined in this SPD.

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

Designated Network Benefits and Network Benefits

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

Non-Network Benefits

When Covered Health Services are received from a non-Network provider as described below, Eligible Expenses are determined as follows:

- When Covered Health Services are received from a non-Network provider as arranged by the Claims Administrator, including when there is no Network provider who is reasonably accessible or available to provide Covered Health Services. Eligible Expenses are an amount negotiated by the Claims Administrator or an amount permitted by law. Please contact the Claims Administrator if you are billed

for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

- **For non-Emergency Covered Health Services received at a Specified Network Facility from Specified Non-Network Providers** when such services are (i) Ancillary Services, (ii) non-Ancillary Services for which the notice and consent criteria of section *2799B-2(d) of the Public Service Act* have not been satisfied, **or** (iii) are non-Ancillary Services for which the notice and consent criteria of section *2799B-2(d) of the Public Service Act* have been satisfied but the Covered Health Service is the result of unforeseen urgent medical needs, the Eligible Expense is based on the "out-of-network rate" as such term is defined in section 716(a)(3)(K) of ERISA and regulations issued thereunder.
- **IMPORTANT NOTICE:** For Ancillary Services, non-Ancillary Services provided for which notice and consent have not been satisfied, and non-Ancillary Services for unforeseen urgent medical needs that arise even if the notice and consent criteria are satisfied, you are not responsible, and a Specified Non-Network Provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Deductible which is based on the Recognized Amount as defined in this SPD.
- **For Emergency Health Services provided by a Non-Network Emergency Facility or a Specified Non-Network Provider**, the Eligible Expense is determined in accordance with section 716(a)(3)(K) of ERISA and regulations issued thereunder.

  IMPORTANT NOTICE: You are not responsible, and a Non-Network Emergency facility or a Specified Non-Network Provider may not bill you, for amounts in excess of your applicable Copayment, Coinsurance or Deductible which is based on the Recognized Amount as defined in this SPD.
- **For Air Ambulance transportation provided by a non-Network provider**, the Eligible Expense is determined in accordance with section 717(b) of ERISA and regulations issued thereunder.

  IMPORTANT NOTICE: You are not responsible, and a non-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or Deductible which is based on the Recognized Amount as defined in this SPD.
- **For Emergency ground ambulance transportation provided by a non-Network provider,** the Eligible Expense, which includes mileage, is a rate agreed upon by the non-Network provider or, unless a different amount is required by applicable law, determined based upon the median amount negotiated with Network providers for the same or similar service.
- **IMPORTANT NOTICE:** Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.
- .**In cases other than those listed above, w**hen Covered Health Services are received from a non-Network provider Eligible Expenses are determined, based on one of the following:

- 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 applies based on the claim type:

Non-Network Facility Provider

- For Covered Health Services provided by a non-Network facility provider or certain ancillary providers, Eligible Expenses are determined based on a methodology developed by UnitedHealthcare or UnitedHealthcare's vendor which calculates the non-Network provider's reimbursement.
- The methodology uses either a percentage of the published rate allowed by the Centers for Medicare & Medicaid Services (CMS) for Medicare or the amount generated by the vendor's pricing tool. The reimbursement methodology that UnitedHealthcare uses is driven by what service was provided and what is allowed under law. This approach is designed to preempt conflicts over reimbursement and balance billing for the member. If issues arise after the initial claim processing, UnitedHealthcare will advocate on behalf of the member and work with the provider to reach agreement on a reimbursement amount that is consistent with the industry trend. The vendor's process is based on a patented pricing tool that recommends a reimbursement amount using paid claims data from millions of claims, many different payers, and many different patients across a distribution of age, gender and location that reflects the U.S. Census.

The vendor's database, utilizes when available Centers for Medicare and Medicaid (CMS) data for hospitals and other facilities and providers to identify the cost structure for those providers and services in a similar category to determine the national median rate which is adjusted to take into account factors that include, but are not limited to, margin markup, geographical area, and the place of service. UnitedHealthcare may modify the reimbursement methodology to maintain the reasonableness of the Eligible Expense.

Non-Network Physician Healthcare Provider

For Covered Health Services provided by a non-Network Physician/Healthcare Provider or certain ancillary providers, Eligible Expenses are determined based on a methodology developed by UnitedHealthcare or UnitedHealthcare's vendor which calculates the non-Network provider's reimbursement.

The methodology uses either a percentage of the published rate allowed by the Centers for Medicare & Medicaid Services (CMS) for Medicare or the amount generated by the vendor's pricing tool. The reimbursement methodology that UnitedHealthcare uses is driven by what service was provided and what is allowed under law. This approach is designed to preempt conflicts over reimbursement and balance billing for the member. If issues arise after the initial claim processing, UnitedHealthcare will advocate on behalf of the member and work with the provider to reach agreement on a reimbursement amount that is consistent with the industry trend. The vendor's process is based on a patented pricing tool that recommends a reimbursement amount using paid claims data from millions of claims, many different payers

and many different patients across a distribution of age, gender and location that reflects the U.S. Census.

The vendor's database includes recently-available national private professional and ancillary provider claims data. The national median rate is determined for procedure codes on the non-Network provider's claim, which is adjusted to take into account factors that include, but are not limited to, general provider expenses, the geographic area, the place of service, and the relative amount of time, level of skill and intensity of the Covered Health Services performed. UnitedHealthcare may modify the reimbursement methodology to maintain the reasonableness of the Eligible Expense.

Non-Network Durable Medical Equipment or Laboratory
For Covered Health Services provided by non-Network laboratory or durable medical equipment providers, Eligible Expenses are determined based on a methodology developed by UnitedHealthcare or UnitedHealthcare's vendor which calculates the non-Network provider's reimbursement by utilizing the median amount negotiated with Network providers for the same type of equipment or service in the same CMS locality.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense except as prohibited by applicable law. Balance billing may occur when notice and consent is satisfied as described under section *2799B-2(d) of the Public Health Service Act.*

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

Eligible Expenses (for Medicare Supplement Health 1 and Medicare Supplement Health 2 Options)

The Plan Administrator has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Eligible Expenses are the amount UnitedHealthcare determines that the Plan will pay for Benefits before taking into account whether the Plan is primary or secondary (for an explanation of when the Plan is primary or secondary, see Section 10, *Coordination of Benefits)*. Eligible Expenses include any applicable Copayment, Coinsurance or Deductible.

Providers may request that you pay all charges when services are rendered. You must file a claim with UnitedHealthcare for reimbursement of Eligible Expenses.

For the Medicare Supplement Health 1 and Medicare Supplement Health 2 options, Eligible Expenses are the "allowable expense" as described in Section 10, *Determining the Allowable expense When This Plan is Secondary to Medicare.*
However, when Covered Health Services are received from a provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law.

Don't Forget Your ID Card
Remember to show your ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of certain Eligible Expenses or the Recognized Amount when applicable, 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. Any coupons or discount offers from pharmaceutical companies or their affiliates are not treated as payments by you and do not count towards your Annual Deductible. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year. Not all Eligible Expenses or the Recognized Amount are subject to the Annual Deductible. Generally, any amount you pay towards your in-Network Annual Deductible also counts towards the applicable Network Out-of-Pocket Limit, while amounts you pay towards the non-Network Annual Deductible also counts towards your Non-Network Out-of-Pocket Limit. However, any Recognized Amount you pay to a Specified Non-Network Provider, to a Non-Network Emergency Facility or to a non-Network provider for Air Ambulance services, other than a Copayment, is applied to you Network Annual Deductible and is counted towards the applicable Network Out-of-Pocket Limit.

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.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. A Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Under Health 1 and Health 2 all Copays except for prescription drug Copays

count towards the regular Out-of-Pocket Limit. Under Health 1 and Health 2 there is a separate Out-of-Pocket Limit for prescription drug Copays. The CDHP option has only one Out-of-Pocket Limit that includes all Copays, including prescription drug Copays. See Out-of-Pocket Limits below.

Coinsurance

Coinsurance is a fixed percentage of Eligible Expenses that you are responsible for paying for certain Covered Health Services after you have satisfied the applicable Annual Deductible. Under Health 1 and Health 2 all Coinsurance except for prescription drug Coinsurance counts towards the regular Out-of-Pocket Limit. Under Health 1 and Health 2 there is a separate Out-of-Pocket Limit for prescription drug Coinsurance. The CDHP option has only one Out-of-Pocket Limit that includes all Coinsurance, including prescription drug Coinsurance. See Out-of-Pocket Limits below.

Coinsurance - Example
Let's assume that you have covered outpatient surgery from a Network provider. Under the Health 1 option, the Plan pays 90% after you have met the Annual Deductible. You are responsible for paying the remaining 10%. This 10% is your Coinsurance.

Out-of-Pocket Limits

An annual Out-of-Pocket Limit is the most you pay each calendar year for certain Covered Health Services.

The Health 1 and Health 2 options each have two sets of annual Out-of-Pocket Limits – one that includes the Annual Deductible, Coinsurance and Copays other than prescription drug Coinsurance and Copays (the regular Out-of-Pocket Limit), and a second solely for prescription drug Coinsurance and Copays. In addition, under Health 1 and Health 2, there are separate Network and non-Network Out-of-Pocket Limits.

The CDHP option has only one annual Network Out-of-Pocket Limit that includes the Annual Deductible, Coinsurance and all Copays, including prescription drug Coinsurance and Copays. In addition, under the CDHP there is a separate non-Network Out-of-Pocket Limit.

If your eligible out-of-pocket expenses (Annual Deductible, Coinsurance and Copays) in a calendar year reach the applicable annual Out-of-Pocket Limit during the calendar year, the Plan then pays 100% of any subsequent Eligible Expenses for Covered Health Services through the end of the calendar year.

Any coupons or discount offers from pharmaceutical companies or their affiliates are not treated as payments by you and do not count towards your annual Out-of-Pocket Limits.

The following tables identify what does and does not apply toward the Out-of-Pocket Limits:

Health 1 and Health 2 Options.

Plan Features	Applies to the Network Out-of-Pocket Limit?	Applies to the Non-Network Out-of-Pocket Limit?
Copays, except for prescription drug Copays. Prescription drug Copays count towards a separate Out-of-Pocket Limit in Section 15, *Outpatient Prescription Drugs*.	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments, except for prescription drug Coinsurance. Prescription drug Coinsurance counts towards a separate Out-of-Pocket Limit in Section 15, *Outpatient Prescription Drugs*.	Yes	Yes
Charges for non-Covered Health Services	No	No
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable	No	No
Ancillary Charges described in Section 15, *Outpatient Prescription Drugs*.	Apply towards a separate Out-of-Pocket Limit described in Section 15, *Outpatient Prescription Drugs*	Not Applicable

CDHP Option.

Plan Features	Applies to the Network Out-of-Pocket Limit?	Applies to the Non-Network Out-of-Pocket Limit?
Copays.	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments, including those for Covered Health Services available in Section 15, *Outpatient Prescription Drugs*.	Yes	Yes
Charges for non-Covered Health Services	No	No

Plan Features	Applies to the Network Out-of-Pocket Limit?	Applies to the Non-Network Out-of-Pocket Limit?
Charges that exceed Eligible Expenses, or the Recognized Amount when applicable	No	No
Ancillary Charges described in Section 15, *Outpatient Prescription Drugs*.	Yes	Not Applicable

SECTION 4 - PERSONAL HEALTH SUPPORT AND PRIOR AUTHORIZATION

What this section includes:

- An overview of the Personal Health Support program.
- Covered Health Services for which you should obtain Prior Authorization.

Care Management

Since most health services must be Medically Necessary to be Covered Health Services, it is recommended that prior authorization be obtained before you receive scheduled (non-Emergency) health services. See *Prior Authorization* below in this section. When you seek prior authorization, the Claims Administrator can determine if the health service is Medically Necessary, and it will work with you and your provider to implement the care management process and to provide information about additional services that are available, such as disease management programs, health education, and patient advocacy.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

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

Personal Health Support 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.

Personal Health Support 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 Personal Health Support program includes:

- **Admission Counseling** - Personal Health Support Nurses are available to help you prepare for a successful surgical admission and recovery. Call the number on your ID card for support.
- **Inpatient Care Managemen**t - If you are hospitalized, a 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 Personal Health Support Nurse to confirm that medications, needed equipment, or

follow-up services are in place. The Personal Health Support 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 Personal Health Support Nurse to discuss and share important health care information related to the participant's specific chronic or complex condition.
- **Cancer Management** - You have the opportunity to engage with a nurse that specializes in cancer treatment, education and guidance throughout your care path.
- **Kidney Management** - You have the opportunity to engage with a nurse that specializes in kidney disease treatment, education and guidance with Chronic Kidney Disease (CKD) stage 4/5 or End Stage Renal Disease (ESRD) throughout your care path.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the number on your ID card.

Prior Authorization For The Health 1 PPO, Health 2 PPO and CDHP Options

Most health services must be Medically Necessary to be Covered Health Services under the Plan. Accordingly, it is strongly recommended that you obtain prior authorization before you receive scheduled (non-Emergency) health services so that UnitedHealthcare can determine whether the health service is Medically Necessary before you receive it. **If prior authorization is not obtained and UnitedHealthcare determines that the health service was not Medically Necessary, you may be responsible for all charges for the health service.** In general, your Network Primary Physician or other Network provider will obtain prior authorization before they provide scheduled (non-Emergency) health services to you. In the case of a non-Network provider, you should contact UnitedHealthcare to obtain prior authorization for scheduled (non-Emergency) health services. For detailed information on the Covered Health Services for which you should obtain prior authorization, please refer to Section 6, *Additional Coverage Details*.

To be a Covered Health Service, most health services must be Medically Necessary. For this reason, it is strongly recommended that if you will be receiving a scheduled (non-Emergency) health service the Claims Administrator be contacted in advance so that it can determine if the health service is Medically Necessary. If the provider is a Network provider, it is supposed to contact the Claims Administrator in advance to obtain prior authorization. **However, it is recommended that you contact the Claims Administrator to verify that the Hospital, Physician or other provider is a Network provider and that the provider has obtained prior authorization.** Network facilities and Network providers should not bill you for services they fail to prior authorization as required. You can contact the Claims Administrator by calling the number on your ID card.

When you choose to receive scheduled (non-Emergency) health services from non-Network providers, you should contact the Claims Administrator to obtain prior authorization before

you receive the health services. You should also contact the Claims Administrator to obtain prior authorization when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To contact the Claims Administrator to obtain prior authorization, call the number on your ID card. This call starts a utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Contacting UnitedHealthcare or Personal Health Support is easy.
Simply call the number on your ID card.

Network providers are generally responsible for contacting the Claims Administrator to obtain prior authorization. However, it is strongly recommended that you contact the Claims Administrator to ensure that prior authorization was obtained from the Claims Administrator.

When you choose to receive certain health services from non-Network providers, you should obtain prior authorization from the Claims Administrator before you receive the services.

If prior authorization is not received and the Claims Administrator determines that the health service was not Medically Necessary, you may be responsible for all charges for the service.

Scheduled (non-Emergency) services for which prior authorization should be obtained are identified in Section 6, *Additional Coverage Details*, within each Covered Health Service Benefit description. Refer to the applicable Benefit description to determine how far in advance prior authorization should be obtained.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in Section 10, *Coordination of Benefits (COB)*. You are not required to obtain prior authorization before receiving Covered Health Services.

SECTION 5 - PLAN HIGHLIGHTS

What this section includes:
- Payment Terms and Features.
- Schedule of Benefits.

Payment Terms and Features Health 1 PPO

The table below provides an overview of Copays that apply when you are enrolled in Health 1 and you receive certain Covered Health Services. It also outlines the Health 1 Annual Deductible and Out-of-Pocket Limits.

Plan Features	Network Amounts	Non-Network Amounts
Copays		
In 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. These Copays apply toward the Annual Out-of-Pocket Limit.		
■ Emergency Health Services.	$100	$100
■ Physician's Office Services - Primary Physician.	$20	Not Applicable*
■ Physician's Office Services - Specialist.	$35	Not Applicable*
■ Urgent Care Center Services.	$40	Not Applicable*
■ Telemedicine through Teladoc	$10**	Not Available
*For these Non-Network services the Plan pays 70% of the Eligible Expense after the Annual Deductible is met.		
**There is a $35 copay for dermatology services through Telemedicine.		
Annual Deductible		
■ Individual.	$250	$500
■ Family (not to exceed the applicable Individual amount per Covered Person).	$500	$1,000

Plan Features	Network Amounts	Non-Network Amounts
Annual Out-of-Pocket Limit**		
■ Individual.	$1,000	$2,000
■ Family (not to exceed the applicable Individual amount per Covered Person).	$2,000	$4,000
**The Annual Deductible, Coinsurance and Copays (except prescription drug Coinsurance and Copays) apply toward this Out-of-Pocket Limit. There is a separate Out-of-Pocket Limit for prescription drug Coinsurance and Copays. See Section 15, *Outpatient Prescription Drugs*.		

Lifetime Maximum Benefit

There is no dollar limit to the amount the Plan will pay for Benefits during the entire period you are enrolled in this Plan, except for fertility services and wigs. There is a $20,000 or $10,000 lifetime maximum for fertility services, depending upon where the services are provided. See *Fertility Services* in Section 6, *Additional Coverage Details*. There is a $500 lifetime maximum for wigs. See *Wigs* in Section 6, *Additional Coverage Details*.

Schedule of Benefits Health 1 PPO

This table provides a general overview of your cost sharing responsibility under the Plan under the Health 1 option after you meet the Annual Deductible. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Amounts which you are required to pay are generally the difference between the amount the Plan pays and the Eligible Expense for a particular Covered Health Service. However, in the case of Covered Health Services provided by a non-Network provider, the amount you pay may be based on the Recognized Amount or may include charges in excess of the Eligible Expense. For more information, see *Eligible Expenses (for Health 1, Health 2 and CDHP Options*) in Section 3, *How the Plan Works*.

Health 1 PPO **Covered Health Services**[1]	***(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount*)**	
	Network	**Non-Network**
Acupuncture Services See Section 6, *Additional Coverage Details*, for limits.	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Ambulance Services – Ground or Air ■ Emergency Ambulance	10% after you meet the Annual Deductible	Same as Network
■ Non-Emergency Ambulance Ground or Air Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for ground and Air Ambulance services provided by a non-Network provider will be determined as described in Section 3, *How the Plan Works*.	10% after you meet the Annual Deductible	Same as Network

Health 1 PPO **Covered Health Services**[1]	*(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Cellular and Gene Therapy Services must be received at a Designated Provider.	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.	Non-Network Benefits are not available
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Congenital Heart Disease (CHD) Surgeries See Section 6, *Additional Coverage Details* for limits.	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Dental Services - Accident Only	No cost sharing after you pay a Copayment of $35 per visit	30% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible

Health 1 PPO **Covered Health Services**[1]	*(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Diabetes Self-Management Items (any prescription drugs are covered under Section 15, *Outpatient Prescription Drugs*.) See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Emergency Health Services - Outpatient 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. Eligible Expenses for Emergency Health Services provided by a Non-Network Emergency Facility or a Specified Non-Network Provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.	No cost sharing after you pay a Copayment of $100 per visit	Same as Network
Fertility Services See Section 6, *Additional Coverage Details*, for limits. This limit does not include Physician office visits for the treatment of fertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Gender Dysphoria	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible

Health 1 PPO **Covered Health Services**[1]	*(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Hearing Aids See Section 6, *Additional Coverage Details*, for limits	No cost sharing	No cost sharing
Home Health Care See Section 6, *Additional Coverage Details*, for limits	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Hospice Care	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Hospital – Inpatient Stay	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient ■ Lab Testing – Outpatient. ■ X-Ray and Other Diagnostic Testing – Outpatient.	10% after you meet the Annual Deductible 10% after you meet the Annual Deductible	30% after you meet the Annual Deductible 30% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Mental Health Services ■ Inpatient. ■ Outpatient Office Visits	10% after you meet the Annual Deductible No cost sharing after you pay a	30% after you meet the Annual Deductible

Health 1 PPO **Covered Health Services**[1]	*(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
All Other Outpatient	Copayment of $20 per visit 10% after you meet the Annual Deductible	30% after you meet the Annual Deductible 30% after you meet the Annual Deductible
Neurobiological Disorders – Autism Spectrum Disorders ■ Inpatient ■ Outpatient Office Visits All Other Outpatient	10% after you meet the Annual Deductible No cost sharing after you pay a Copayment of $20 per visit 10% after you meet the Annual Deductible	30% after you meet the Annual Deductible 30% after you meet the Annual Deductible 30% after you meet the Annual Deductible
Nutritional Counseling See Section 6, *Additional Coverage Details* for limits	No cost sharing	No cost sharing
Obesity Surgery See Section 6, *Additional Coverage Details* for limits.	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Ostomy Supplies See Section 6, *Additional Coverage Details* for limits	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible

Health 1 PPO **Covered Health Services**[1]	*(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Pharmaceutical Products – Outpatient Administered by Provider For certain Specialty Pharmaceutical Products your cost sharing responsibility may be lower. See Section 6, *Pharmaceutical Products - Outpatient* for additional information.	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Some Covered Health Services provided by a Specified Non-Network Provider in a Specified Network Facility will apply the same cost sharing (Copayment, Coinsurance and applicable Deductible) as if those services were provided by a Network provider with the cost sharing based on the Recognized Amount rather than the Eligible Expense.	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Physician's Office Services – Sickness and Injury ■ Primary Physician.	No cost sharing after you pay a Copayment of $20 per visit	30% after you meet the Annual Deductible
■ Specialist Physician.	No cost sharing after you pay a Copayment of $35 per visit	30% after you meet the Annual Deductible

Health 1 PPO **Covered Health Services**[1]	*(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Pregnancy – Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section.	Benefits will be the same as those stated under each Covered Health Service category in this section.
Preventive Care Services		
■ Physician Office Services.	No cost sharing	30% after you meet the Annual Deductible
■ Colorectal Cancer Screenings (includes colonoscopies, sigmoidoscopies, barium enema, blood occult) and Routine PAP	No cost sharing	30% after you meet the Annual Deductible
■ Mammogram and Expanded WHCR Services	No cost sharing	30% after you meet the Annual Deductible
■ Lab, X-ray and all Other Preventive Tests.	No cost sharing	30% after you meet the Annual Deductible
■ Breast Pumps.	No cost sharing	30% after you meet the Annual Deductible
Private Duty Nursing - Outpatient See Section 6, *Additional Coverage Details*, for limits	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Reconstructive Procedures	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible

Health 1 PPO **Covered Health Services**[1]	*(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Substance-Related and Addictive Disorder Services		
■ Inpatient.	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
■ Outpatient Office Visits	No cost sharing after you pay a Copayment of $20 per visit	30% after you meet the Annual Deductible
All Other Outpatient	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible

Health 1 PPO **Covered Health Services**[1]	*(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Surgery - Outpatient	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Telemedicine through Teladoc	No cost sharing after you pay a Copayment of $10 per call ($35 Copay for dermatology)	Not Available
Therapeutic Treatments - Outpatient	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
■ Dialysis	10% after you meet the Annual Deductible	Not Available
Transplantation Services See Section 6, *Additional Coverage Details* for limits.	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
Travel and Lodging Covered Health Services must be received at a Centers of Excellence. See Section 7, *Clinical Programs and Resources* for limits.	For the patient and a companion of the patient undergoing medical treatment or procedures at a Centers of Excellence. Whether benefits are available and the level of benefits depends on the distance the patient and companion must travel to the Centers of Excellence	
Urgent Care Center Services	No cost sharing after you pay a Copayment of $40 per visit	30% after you meet the Annual Deductible

Health 1 PPO **Covered Health Services**[1]	*(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Urinary Catheters	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible
■ Physician Office Services.	No cost sharing	30% after you meet the Annual Deductible
Wigs See Section 6, *Additional Coverage Details*, for limits.	10% after you meet the Annual Deductible	30% after you meet the Annual Deductible

[1]It is recommended that for scheduled (non-Emergency) health services that you or your provider contact the Claims Administrator beforehand to obtain prior authorization before receiving the health services.

Payment Terms and Features Health 2 PPO

The table below provides an overview of Copays that apply when you are enrolled in Health 2 and you receive certain Covered Health Services. It also outlines the Health 2 Annual Deductible and Out-of-Pocket Limits.

Plan Features	Network Amounts	Non-Network Amounts
Copays		
In 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. These Copays apply towards the Annual Out-of-Pocket Limit.		
■ Emergency Health Services.	$100	$100
■ Physician's Office Services - Primary Physician.	$20	Not Applicable*
■ Physician's Office Services - Specialist.	$35	Not Applicable*
■ Urgent Care Center Services.	$40	Not Applicable*
■ Telemedicine through Teladoc	$10**	Not Available
*For these Non-Network services the Plan pays 60% of the Eligible Expense after the Annual Deductible is met.		
**There is a $35 copay for dermatology services through Telemedicine.		
Annual Deductible		
■ Individual.	$500	$1,000
■ Family (not to exceed the applicable Individual amount per Covered Person).	$1,000	$2,000

Plan Features	Network Amounts	Non-Network Amounts
Annual Out-of-Pocket Limit**		
■ Individual.	$2,500	$4,000
■ Family (not to exceed the applicable Individual amount per Covered Person).	$4,000	$6,000
**The Annual Deductible, Coinsurance and Copays (except prescription drug Coinsurance and Copays) apply toward this Out-of-Pocket Limit. There is a separate Out-of-Pocket Limit for prescription drug Coinsurance and Copays. See Section 15 *Outpatient Prescription Drugs*.		

Lifetime Maximum Benefit

There is no dollar limit to the amount the Plan will pay for Benefits during the entire period you are enrolled in this Plan, except for fertility services and wigs. There is a $20,000 or $10,000 lifetime maximum for fertility services, depending upon where the services are provided. See *Fertility Services* in Section 6, *Additional Coverage Details*. There is a $500 lifetime maximum for wigs. See *Wigs* in Section 6, *Additional Coverage Details*.

Schedule of Benefits Health 2 PPO

This table provides a general overview of your cost sharing responsibility under the Plan under the Health 2 option after you meet the Annual Deductible. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Amounts which you are required to pay are generally the difference between the amount the Plan pays and the Eligible Expense for a particular Covered Health Service. However, in the case of Covered Health Services provided by a non-Network provider, the amount you pay may be based on the Recognized Amount or may include charges in excess of the Eligible Expense. For more information, see *Eligible Expenses (for Health 1, Health 2 and CDHP Options*) in Section 3, *How the Plan Works*.

Health 2 PPO **Covered Health Services**[1]	**Benefit** ***(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount*)**	
	Network	**Non-Network**
Acupuncture Services See Section 6, *Additional Coverage Details*, for limits.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Ambulance Services – Ground or Air ■ Emergency Ambulance	20% after you meet the Annual Deductible	Same as Network
■ Non-Emergency Ambulance Ground or Air Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for ground and Air Ambulance services provided by a non-Network provider will be determined as described in Section 3, *How the Plan Works*.	20% after you meet the Annual Deductible	Same as Network

Health 2 PPO **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Cellular and Gene Therapy Services must be received at a Designated Provider	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.	Non-Network Benefits are not available
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Congenital Heart Disease (CHD) Surgeries See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Dental Services – Accident Only	No cost sharing after you pay a Copayment of $35 per visit	40% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Health 2 PPO **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Diabetes Self-Management Items (any prescription drugs are covered under Section 15, *Outpatient Prescription Drugs*). See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Emergency Health Services – Outpatient 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. Eligible Expenses for Emergency Health Services provided by a Non-Network Emergency Facility or a Specified Non-Network Provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.	No cost sharing after you pay a Copayment of $100 per visit	Same as Network
Fertility Services See Section 6, *Additional Coverage Details*, for limits. This limit does not include Physician office visits for the treatment of fertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Gender Dysphoria	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Health 2 PPO **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Hearing Aids See Section 6, *Additional Coverage Details*, for limits	No cost sharing	No cost sharing
Home Health Care See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Hospice Care See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Hospital – Inpatient Stay	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient		
■ Lab Testing – Outpatient.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ X-Ray and Other Diagnostic Testing – Outpatient.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Health 2 PPO **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Mental Health Services		
■ Inpatient.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ Outpatient Office Visits	No cost sharing after you pay a Copayment of $20 per visit	40% after you meet the Annual Deductible
All Other Outpatient	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Neurobiological Disorders –Autism Spectrum Disorders		
■ Inpatient.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ Outpatient Office Visit	No cost sharing after you pay a Copayment of $20 per visit	40% after you meet the Annual Deductible
All Other Outpatient	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Nutritional Counseling See Section 6, *Additional Coverage Details* for limits	No cost sharing	No cost sharing
Obesity Surgery See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Health 2 PPO **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Ostomy Supplies See Section 6, *Additional Coverage Details* for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Pharmaceutical Products – Outpatient Administered by Provider For certain Specialty Pharmaceutical Products your cost sharing responsibility may be lower. See Section 6, *Pharmaceutical Products - Outpatient* for additional information.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Some Covered Health Services provided by a Specified Non-Network Provider in a Specified Network Facility will apply the same cost sharing (Copayment, Coinsurance and applicable Deductible) as if those services were provided by a Network provider with the cost sharing based on the Recognized Amount rather than the Eligible Expense.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Physician's Office Services – Sickness and Injury		
■ Primary Physician.	No cost sharing after you pay a Copayment of $20 per visit	40% after you meet the Annual Deductible
■ Specialist Physician.	No cost sharing after you pay a Copayment of $35 per visit	40% after you meet the Annual Deductible

Health 2 PPO **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Pregnancy – Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section.	Benefits will be the same as those stated under each Covered Health Service category in this section.
Preventive Care Services		
■ Physician Office Services.	No cost sharing	40% after you meet the Annual Deductible
■ Colorectal Cancer Screenings (includes colonoscopies, sigmoidoscopies, barium enema, blood occult) and Routine PAP	No cost sharing	40% after you meet the Annual Deductible
■ Mammogram and Expanded WHCR Services	No cost sharing	40% after you meet the Annual Deductible
■ Lab, X-ray and all Other Preventive Tests.	No cost sharing	40% after you meet the Annual Deductible
■ Breast Pumps.	No cost sharing	40% after you meet the Annual Deductible
Private Duty Nursing – Outpatient See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Reconstructive Procedures	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Health 2 PPO **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Rehabilitation Services – Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Scopic Procedures – Outpatient Diagnostic and Therapeutic	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Substance-Related and Addictive Disorder Services		
■ Inpatient.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ Outpatient Office Visit.	No cost sharing after you pay a Copayment of $20 per visit	40% after you meet the Annual Deductible
All Other Outpatient	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

Health 2 PPO **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Surgery – Outpatient	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Telemedicine through Teladoc	No cost sharing after you pay a Copayment of $10 per call ($35 Copay for dermatology)	Not Available
Therapeutic Treatments – Outpatient ■ Dialysis	20% after you meet the Annual Deductible 20% after you meet the Annual Deductible	40% after you meet the Annual Deductible Not Available
Transplantation Services See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Travel and Lodging Covered Health Services must be received at a Centers of Excellence. See Section 7, *Clinical Programs and Resources* for limits.	For the patient and a companion of the patient undergoing medical treatment or procedures at a Centers of Excellence. Whether benefits are available and the level of benefits depends on the distance the patient and companion must travel to the Centers of Excellence	
Urgent Care Center Services	No cost sharing after you pay a Copayment of $40 per visit	40% after you meet the Annual Deductible

Health 2 PPO **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Urinary Catheters	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ Physician Office Services.	No cost sharing	40% after you meet the Annual Deductible
Wigs See Section 6, *Additional Coverage Details*, for limits.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

[1]It is recommended that for scheduled (non-Emergency) health services that you or your provider contact the Claims Administrator beforehand to obtain prior authorization before receiving the health services.

Payment Terms and Features CDHP

The table below outlines the Plan's Annual Deductible and Out-of-Pocket Limits when you are enrolled in CDHP.

Plan Features	Network Amounts	Non-Network Amounts
Annual Deductible		
■ Individual.	$2,000	$4,000
■ Family (cumulative Annual Deductible).	$4,000	$8,000
If you have elected any coverage option other than Employee only coverage, the individual coverage Deductible stated in this table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.		
Annual Out-of-Pocket Limit*		
■ Individual.	$3,750	$7,500
■ Family (cumulative Out-of-Pocket Limit).	$7,500	$15,000
If you have elected any coverage option other than Employee only coverage, the individual coverage Out-of-Pocket Limit stated in this table above does not apply. Instead, the family Out-of-Pocket Limit applies.		
*The Annual Deductible, Coinsurance and Copays (including prescription drug Coinsurance and Copays) apply towards this Out-of-Pocket Limit.		

Lifetime Maximum Benefit

There is no dollar limit to the amount the Plan will pay for Benefits during the entire period you are enrolled in this Plan, except for fertility services and wigs. There is a $20,000 or $10,000 lifetime maximum for fertility services, depending upon where the services are provided. See *Fertility Services* in Section 6, *Additional Coverage Details*. There is a $500 lifetime maximum for wigs. See *Wigs* in Section 6, *Additional Coverage Details*.

Schedule of Benefits CDHP

This table provides a general overview of your cost sharing responsibility under the CDHP option after you meet the Annual Deductible. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Amounts which you are required to pay are generally the difference between the amount the Plan pays and the Eligible Expense for a particular Covered Health Service. However, in the case of Covered Health Services provided by a non-Network provider, the amount you pay may be based on the Recognized Amount or may include charges in excess of the Eligible Expense. For more information, see *Eligible Expenses (for Health 1, Health 2 and CDHP Options*) in Section 3, *How the Plan Works*.

CDHP **Covered Health Services**[1]	**Benefit** ***(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount*)**	
	Network	**Non-Network**
Acupuncture Services See Section 6, *Additional Coverage Details*, for limits.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Ambulance Services – Ground or Air ■ Emergency Ambulance	20% after you meet the Annual Deductible	20% after you meet the Network Annual Deductible
■ Non-Emergency Ambulance Ground or Air Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for ground and Air Ambulance services provided by a non-Network provider will be determined as described in Section 3, *How the Plan Works*.	20% after you meet the Annual Deductible	20% after you meet the Network Annual Deductible

CDHP **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Cellular and Gene Therapy Services must be received at a Designated Provider.	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.	Non-Network Benefits are not available
Clinical Trials Benefits are available when the Covered Health Services are provided by either Network or non-Network providers.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Congenital Heart Disease (CHD) Surgeries See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Dental Services - Accident Only	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Diabetes Self-Management Items (any prescription drugs are covered under Section 15, *Outpatient Prescription Drugs*). See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

CDHP **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, the Benefits for an Inpatient Stay in a Hospital will apply instead. Eligible Expenses for Emergency Health Services provided by a Non-Network Emergency Facility or a Specified Non-Network Provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.	20% after you meet the Annual Deductible	20% after you meet the Network Annual Deductible
Fertility Services See Section 6, *Additional Coverage Details*, for limits. This limit does not include Physician office visits for the treatment of fertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Gender Dysphoria	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Hearing Aids See Section 6, *Additional Coverage Details*, for limits	No cost sharing after you meet the Annual Deductible	No cost sharing after you meet the Annual Deductible
Home Health Care See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Hospice Care See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

CDHP **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Hospital – Inpatient Stay	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient		
■ Lab Testing – Outpatient.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ X-Ray and Other Diagnostic Testing – Outpatient.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Mental Health Services		
■ All Inpatient.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ All Outpatient	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Neurobiological Disorders –Autism Spectrum Disorders		
■ All Inpatient.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ All Outpatient	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

CDHP **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Nutritional Counseling See Section 6, *Additional Coverage Details* for limits	No cost sharing after you meet the Annual Deductible	No cost sharing after you meet the Annual Deductible
Obesity Surgery See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Ostomy Supplies See Section 6, *Additional Coverage Details* for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Pharmaceutical Products – Outpatient Administered by Provider	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Some Covered Health Services provided by a Specified Non-Network Provider in a Specified Network Facility will apply the same cost sharing (Copayment, Coinsurance and applicable Deductible) as if those services were provided by a Network provider with the cost sharing based on the Recognized Amount rather than the Eligible Expense.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Physician's Office Services – Sickness and Injury ■ Primary Physician. ■ Specialist Physician.	20% after you meet the Annual Deductible 20% after you meet the Annual Deductible	40% after you meet the Annual Deductible 40% after you meet the Annual Deductible

CDHP **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Pregnancy – Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section.	Benefits will be the same as those stated under each Covered Health Service category in this section.
Preventive Care Services		
■ Physician Office Services.	No cost sharing	40% after you meet the Annual Deductible
■ Colorectal Cancer Screenings (includes colonoscopies, sigmoidoscopies, barium enema, blood occult) and Routine PAP	No cost sharing	40% after you meet the Annual Deductible
■ Mammogram and Expanded WHCR Services	No cost sharing	40% after you meet the Annual Deductible
■ Lab, X-ray and all Other Preventive Tests.	No cost sharing	40% after you meet the Annual Deductible
■ Breast Pumps.	No cost sharing	40% after you meet the Annual Deductible
Private Duty Nursing - Outpatient See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Reconstructive Procedures	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

CDHP **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Substance-Related and Addictive Disorder Services		
■ All Inpatient.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
■ All Outpatient	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Surgery - Outpatient	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

CDHP **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Telemedicine through Teladoc	$10 Copayment per call ($35 Copay for dermatology services) after you meet the Annual Deductible	Not Available
Therapeutic Treatments - Outpatient ■ Dialysis	20% after you meet the Annual Deductible 20% after you meet the Annual Deductible	40% after you meet the Annual Deductible Not Available
Transplantation Services See Section 6, *Additional Coverage Details*, for limits	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Travel and Lodging Covered Health Services must be received at a Centers of Excellence. See Section 7, *Clinical Programs and Resources* for limits.	For the patient and a companion of the patient undergoing medical treatment or procedures at a Centers of Excellence. Whether benefits are available and the level of benefits depends on the distance the patient and companion must travel to the Centers of Excellence. Benefits will be covered once the Annual Deductible is met.	
Urgent Care Center Services	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible
Urinary Catheters	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

CDHP **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses or the Recognized Amount)*	
	Network	**Non-Network**
Wigs See Section 6, *Additional Coverage Details*, for limits.	20% after you meet the Annual Deductible	40% after you meet the Annual Deductible

[1]It is recommended that for scheduled (non-Emergency) health services that you or your provider contact the Claims Administrator beforehand to obtain prior authorization before receiving the health services.

Payment Terms and Features Medicare Supplement Health 1

The table below outlines the Plan's Annual Out-of-Pocket Limit for Medicare Supplement Health 1.

Plan Features	Amounts
Annual Out-of-Pocket Limit	
■ Individual.	$1,000
■ Family (not to exceed the Individual amount per Covered Person).	$2,000

Lifetime Maximum Benefit

There is no dollar limit to the amount the Plan will pay for Benefits during the entire period you are enrolled in this Plan, except for fertility services and wigs. There is a $20,000 or $10,000 lifetime maximum for fertility services, depending upon where the services are provided. See *Fertility Services* in Section 6, *Additional Coverage Details*. There is a $500 lifetime maximum for wigs. See *Wigs* in Section 6, *Additional Coverage Details*.

Schedule of Benefits Medicare Supplement Health 1

This table provides an overview of your cost sharing responsibility under the Plan for the Medicare Supplement Health 1 option. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Eligible Expenses or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 14, *Glossary*.

Medicare Supplement Health 1 **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses)*
Acupuncture Services See Section 6, *Additional Coverage Details*, for limits.	10% of Eligible Expenses
Ambulance Services – Ground or Air ■ Emergency Ambulance ■ Non-Emergency Ambulance Ground or Air ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, *How the Plan Works*	10% of Eligible Expenses 10% of Eligible Expenses
Cellular and Gene Therapy Services must be received at a Designated Provider.	10% of Eligible Expenses
Clinical Trials See Section 6, *Additional Coverage Details*, for limits	10% of Eligible Expenses
Congenital Heart Disease (CHD) Surgeries See Section 6, *Additional Coverage Details* for limits.	10% of Eligible Expenses
Dental Services - Accident Only	10% of Eligible Expenses

Medicare Supplement Health 1 **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses)*
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care Diabetes Self-Management Items (any prescription drugs are covered under Section 15, *Outpatient Prescription Drugs*). See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits	7 10% of Eligible Expenses 10% of Eligible Expenses
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits	10% of Eligible Expenses
Emergency Health Services - Outpatient Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.	10% of Eligible Expenses
Fertility Services See Section 6, *Additional Coverage Details*, for limits. This limit does not include Physician office visits for the treatment of fertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.	10% of Eligible Expenses
Gender Dysphoria	10% of Eligible Expenses
Hearing Aids See Section 6, *Additional Coverage Details*, for limits	No cost sharing

Medicare Supplement Health 1 **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses)*
Home Health Care See Section 6, *Additional Coverage Details*, for limits	10% of Eligible Expenses
Hospice Care See Section 6, *Additional Coverage Details*, for limits	10% of Eligible Expenses
Hospital – Inpatient Stay	10% of Eligible Expenses
Lab, X-Ray and Diagnostics – Outpatient ■ Lab Testing – Outpatient. ■ X-Ray and Other Diagnostic Testing – Outpatient.	 10% of Eligible Expenses 10% of Eligible Expenses
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	10% of Eligible Expenses
Mental Health Services ■ All Inpatient. ■ All Outpatient	 10% of Eligible Expenses 10% of Eligible Expenses
Neurobiological Disorders –Autism Spectrum Disorders ■ All Inpatient. ■ All Outpatient	 10% of Eligible Expenses 10% of Eligible Expenses
Nutritional Counseling See Section 6, *Additional Coverage Details* for limits	No cost sharing

Medicare Supplement Health 1 **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses)*
Obesity Surgery See Section 6, *Additional Coverage Details* for limits.	10% of Eligible Expenses
Ostomy Supplies See Section 6, *Additional Coverage Details* for limits	10% of Eligible Expenses
Pharmaceutical Products – Outpatient Administered by Provider For certain Specialty Pharmaceutical Products your cost sharing responsibility may be lower. See Section 6, *Pharmaceutical Products - Outpatient* for additional information.	10% of Eligible Expenses
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable Deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 3, *How the Plan Works*, under *Eligible Expenses*.	10% of Eligible Expenses
Physician's Office Services – Sickness and Injury ■ Primary Physician. ■ Specialist Physician.	10% of Eligible Expenses 10% of Eligible Expenses
Pregnancy – Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section.

Medicare Supplement Health 1 **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses)*
Preventive Care Services ■ Physician Office Services. ■ Colorectal Cancer Screenings (includes colonoscopies, sigmoidoscopies, barium enema, blood occult) and Routine PAP ■ Mammogram and Expanded WHCR Services ■ Lab, X-ray and all Other Preventive Tests. ■ Breast Pumps.	No cost sharing No cost sharing No cost sharing No cost sharing No cost sharing
Private Duty Nursing - Outpatient See Section 6, *Additional Coverage Details*, for limits	10% of Eligible Expenses
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits	10% of Eligible Expenses
Reconstructive Procedures	10% of Eligible Expenses
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	10% of Eligible Expenses
Scopic Procedures - Outpatient Diagnostic and Therapeutic	10% of Eligible Expenses
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits	10% of Eligible Expenses
Substance-Related and Addictive Disorder Services ■ All Inpatient. ■ All Outpatient	10% of Eligible Expenses 10% of Eligible Expenses

Medicare Supplement Health 1 **Covered Health Services**[1]	**Benefit** *(Your cost sharing responsibility under the Plan based on Eligible Expenses)*
Surgery - Outpatient	10% of Eligible Expenses
Therapeutic Treatments - Outpatient	10% of Eligible Expenses
Transplantation Services See Section 6, *Additional Coverage Details* for limits.	10% of Eligible Expenses
Travel and Lodging Covered Health Services must be received at a Centers of Excellence. See Section 7, *Clinical Programs and Resources* for limits.	For the patient and a companion of the patient undergoing medical treatment or procedures at a Centers of Excellence. Whether benefits are available and the level of benefits depends on the distance the patient and companion must travel to the Centers of Excellence.
Urgent Care Center Services	10% of Eligible Expenses
Urinary Catheters	10% of Eligible Expenses
Wigs See Section 6, *Additional Coverage Details*, for limits.	10% of Eligible Expenses

Payment Terms and Features Medicare Supplement Health 2

The table below outlines the Plan's Out-of-Pocket Limit for Medicare Supplement Health 2.

Plan Features	Amounts
Annual Out-of-Pocket Limit	
■ Individual.	$1,500
■ Family (not to exceed the Individual amount per Covered Person).	$3,000

Lifetime Maximum Benefit

There is no dollar limit to the amount the Plan will pay for Benefits during the entire period you are enrolled in this Plan, except for fertility services and wigs. There is a $20,000 or $10,000 lifetime maximum for fertility services, depending upon where the services are provided. See *Fertility Services* in Section 6, *Additional Coverage Details*. There is a $500 lifetime maximum for wigs. See *Wigs* in Section 6, *Additional Coverage Details*.

Schedule of Benefits Medicare Supplement Health 2

This table provides an overview of your cost sharing responsibility under the Plan for the Medicare Supplement Health 2. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Eligible Expenses or, for specific Covered Health Services as described in the definition of Recognized Amount in Section 14, Glossary.

Medicare Supplement Health 2 **Covered Health Services**[1]	**Benefit** **(*Your cost sharing responsibility under the Plan based on Eligible Expenses*)**
Acupuncture Services See Section 6, *Additional Coverage Details*, for limits.	20% of Eligible Expenses
Ambulance Services – Ground or Air Emergency Ambulance ■ Non-Emergency Ambulance Ground or Air Ambulance, as the Claims Administrator determines appropriate. Eligible Expenses for ground and Air Ambulance transport provided by a non-Network provider will be determined as described in Section 3, *How the Plan Works*.	20% of Eligible Expenses 20% of Eligible Expenses
Cellular and Gene Therapy Services must be received at a Designated Provider.	20% of Eligible Expenses
Clinical Trials See Section 6, *Additional Coverage Details*, for limits	20% of Eligible Expenses
Congenital Heart Disease (CHD) Surgeries See Section 6, *Additional Coverage Details*, for limits	20% of Eligible Expenses
Dental Services - Accident Only	20% of Eligible Expenses

Medicare Supplement Health 2 **Covered Health Services**[1]	**Benefit** **(*Your cost sharing responsibility under the Plan based on Eligible Expenses*)**
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care Diabetes Self-Management Items (any prescription drugs are covered under Section 15, *Outpatient Prescription Drugs*). See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits	20% of Eligible Expenses 20% of Eligible Expenses
Durable Medical Equipment (DME) See *Durable Medical Equipment* in Section 6, *Additional Coverage Details*, for limits	20% of Eligible Expenses
Emergency Health Services - Outpatient Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described under *Eligible Expenses* in Section 3: *How the Plan Works*.	20% of Eligible Expenses
Fertility Services See Section 6, *Additional Coverage Details*, for limits. This limit does not include Physician office visits for the treatment of fertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.	20% of Eligible Expenses
Gender Dysphoria	20% of Eligible Expenses
Hearing Aids See Section 6, *Additional Coverage Details*, for limits	No cost sharing

Medicare Supplement Health 2 **Covered Health Services**[1]	**Benefit** **(*Your cost sharing responsibility under the Plan based on Eligible Expenses*)**
Home Health Care See Section 6, *Additional Coverage Details*, for limits	20% of Eligible Expenses
Hospice Care See Section 6, *Additional Coverage Details*, for limits	20% of Eligible Expenses
Hospital – Inpatient Stay	20% of Eligible Expenses
Lab, X-Ray and Diagnostics – Outpatient ■ Lab Testing – Outpatient. ■ X-Ray and Other Diagnostic Testing – Outpatient.	20% of Eligible Expenses 20% of Eligible Expenses
Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	20% of Eligible Expenses
Mental Health Services ■ All Inpatient. ■ All Outpatient	20% of Eligible Expenses 20% of Eligible Expenses
Neurobiological Disorders –Autism Spectrum Disorders ■ All Inpatient. ■ All Outpatient.	20% of Eligible Expenses 20% of Eligible Expenses
Nutritional Counseling See Section 6, *Additional Coverage Details* for limits	No cost sharing
Obesity Surgery See Section 6, *Additional Coverage Details* for limits.	20% of Eligible Expenses

Medicare Supplement Health 2 **Covered Health Services**[1]	**Benefit** **(*Your cost sharing responsibility under the Plan based on Eligible Expenses*)**
Ostomy Supplies See Section 6, *Additional Coverage Details* for limits	20% of Eligible Expenses
Pharmaceutical Products – Outpatient Administered by Provider For certain Specialty Pharmaceutical Products your cost sharing responsibility may be lower. See Section 6, *Pharmaceutical Products - Outpatient* for additional information.	20% of Eligible Expenses
Physician Fees for Surgical and Medical Services Covered Health Services provided by a non-Network Physician in certain Network facilities will apply the same cost sharing (Copayment, Coinsurance and applicable deductible) as if those services were provided by a Network provider; however Eligible Expenses will be determined as described in Section 3, *How the Plan Works*, under *Eligible Expenses*.	20% of Eligible Expenses
Physician's Office Services – Sickness and Injury ■ Primary Physician. ■ Specialist Physician.	 20% of Eligible Expenses 20% of Eligible Expenses
Pregnancy – Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section.
Preventive Care Services ■ Physician Office Services. ■ Colorectal Cancer Screenings (includes colonoscopies, sigmoidoscopies,	 No cost sharing No cost sharing

Medicare Supplement Health 2 **Covered Health Services**[1]	**Benefit** **(*Your cost sharing responsibility under the Plan based on Eligible Expenses*)**
barium enema, blood occult) and Routine Pap ■ Mammogram and Expanded WHCR Services ■ Lab, X-ray and all Other Preventive Tests. ■ Breast Pumps.	No cost sharing No cost sharing No cost sharing
Private Duty Nursing - Outpatient See Section 6, *Additional Coverage Details*, for limits	20% of Eligible Expenses
Prosthetic Devices See Section 6, *Additional Coverage Details*, for limits	20% of Eligible Expenses
Reconstructive Procedures	20% of Eligible Expenses
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, *Additional Coverage Details*, for visit limits.	20% of Eligible Expenses
Scopic Procedures - Outpatient Diagnostic and Therapeutic	20% of Eligible Expenses
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 6, *Additional Coverage Details*, for limits	20% of Eligible Expenses
Substance-Related and Addictive Disorder Services ■ All Inpatient. ■ All Outpatient.	20% of Eligible Expenses 20% of Eligible Expenses

Medicare Supplement Health 2 **Covered Health Services**[1]	**Benefit** **(*Your cost sharing responsibility under the Plan based on Eligible Expenses*)**
Surgery - Outpatient	20% of Eligible Expenses
Therapeutic Treatments - Outpatient	20% of Eligible Expenses
Transplantation Services See Section 6, *Additional Coverage Details*, for limits	20% of Eligible Expenses
Travel and Lodging Covered Health Services must be received at a Centers of Excellence. See Section 7, *Clinical Programs and Resources* for limits.	For the patient and a companion of the patient undergoing medical treatment or procedures a Centers of Excellence. Whether benefits are available and the level of benefits depends on the distance the patient and companion must travel to the Centers of Excellence.
Urgent Care Center Services	20% of Eligible Expenses
Urinary Catheters	20% of Eligible Expenses
Wigs See Section 6, *Additional Coverage Details*, for limits.	20% of Eligible Expenses

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits.
- Scheduled (non-Emergency) Covered Health Services for which prior authorization should be obtained by you or your provider for the Health 1 PPO, Health 2 PPO and CDHP options before you receive them.

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

While the tables in Section 5 provide 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 apply, as well as scheduled (non-Emergency) Covered Health Services for which prior authorization should be obtained by you or your provider from the Claims Administrator for the Health 1 PPO, Health 2 PPO and CDHP options. The Covered Health Services in this section appear in the same order as they do in the tables for easy reference. Services that are not covered are described in Section 8, *Exclusions and Limitations*.

Benefits are provided for otherwise Covered Health Services delivered via Telehealth/Telemedicine. Benefits are also provided for Remote Physiologic Monitoring. Benefits for these services are provided to the same extent as an in-person service under any applicable Benefit category in this section unless otherwise specified in the table.

Unless otherwise specified, a health service must be Medically Necessary in order to be a Covered Health Service. In the case of a scheduled (non-Emergency) health service, it is strongly recommended that you or your provider notify the Claims Administrator in advance so the Claims Administrator can determine whether the health service is Medically Necessary and provide prior authorization. If prior authorization is not obtained and the Claims Administrator determines that the health service was not Medically Necessary, you may be responsible for all charges for the health service.

Acupuncture Services

- The Plan pays for acupuncture services for all covered diagnoses provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:
- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

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

- Chemotherapy.
- Pregnancy.
- Post-operative procedures.

Any combination of Network Benefits and Non-Network Benefits is limited to 25 treatments per calendar year.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

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

The Plan also covers transportation provided by a licensed professional ambulance (either ground or Air Ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

Prior Authorization
In most cases, the Claims Administrator will initiate and direct non-Emergency ambulance transportation. For Non-Network Benefits, if you or your provider are requesting non-Emergency Air Ambulance services, (including any affiliated non-Emergency ground ambulance transport in conjunction with non-Emergency Air Ambulance transport), it is strongly recommended that you or your provider contact the Claims Administrator as soon as possible before transport to obtain prior authorization. If prior authorization is not obtained and it is determined that the non-Emergency ambulance transportation was not Medically Necessary, you may be responsible for all charges.

Cellular and Gene Therapy

Cellular Therapy and Gene Therapy received on an inpatient or outpatient basis at a Hospital or on an outpatient basis at an Alternate Facility or in a Physician's office. Cellular and Gene Therapy must be received from a Designated Provider.

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

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.
- 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 Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the service or item, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for Clinical Trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:

- Certain *Category B* devices.
- Certain promising interventions for patients with terminal illnesses.
- Other items and services that meet specified criteria in accordance with UnitedHealthcare's 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.

- 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, 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.
- 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.
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.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization
It is strongly recommended that you or your provider obtain prior authorization from the Claims Administrator as soon as the possibility of participation in a Clinical Trial arises. If prior authorization is not obtained and it is determined that the health services are not Medically Necessary, you may be responsible for all charges.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) surgeries that are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

UnitedHealthcare has specific guidelines regarding Benefits for CHD services. Contact UnitedHealthcare at the number on your ID card for information about these guidelines.

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).
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by the Claims Administrator to be proven procedures for the involved diagnoses. Contact CHD Resource Services at 1-888-936-7246 before receiving care for information about CHD services. More information is also available at **www.myoptumhealthcomplexmedical.com**.

UnitedHealthcare has a CHD Program that provides access to certain Designated Providers that specialize in CHD surgeries. Through the CHD Program you may be able to qualify for the Travel and Lodging Benefit described in Section 7. To enroll in the CHD Program, you must contact CHD Resource Services at 1-888-936-7246 prior to obtaining CHD services. The Plan will only pay Benefits under the CHD Program if CHD Resource Services provides the proper notification to the Designated Provider performing the services (even if you self-refer to that Designated Provider).

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator as soon as the possibility of a Congenital Heart Disease (CHD) surgery arises to obtain prior authorization. If prior authorization is not obtained and it is determined that the health services are not Medically Necessary, you may be responsible for all charges. When you provide notification, the Claims Administrator can determine what CHD services will be Covered Health Services.

Dental Services - Accident Only

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

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry.

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 having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

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

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

The Plan pays for treatment of accidental Injury only for:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

The Plan also covers the following services:

- Orthognathic surgery.

- Extraction of bony-impacted wisdom teeth.

Anesthesia for dental procedures for children under the age of 5 and disabled dependents regardless of whether the dental procedures are necessary due to accidental damage.

Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye examinations (dilated retinal examinations), footcare for Covered Persons with diabetic foot disease and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. Insulin pumps are covered regardless of cost effectiveness. The Plan pays Benefits for insulin pumps prescribed by a Physician to enhance the Covered Person's ability to live an active, normal life and/or improve the Covered Person's compliance with their overall diabetes treatment plan, including wireless insulin pumps such as Omnipod®.

Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, *Outpatient Prescription Drugs*.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization from the Claims Administrator before acquiring any DME for the management and treatment of diabetes that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If prior authorization is not obtained and it is determined that the DME was not Medically Necessary, you may be responsible for all charges.

Disposable Medical Supplies

The Plan pays Benefits for disposable medical supplies that are prescribed by a Physician and billed by a Physician, Home Health Care Agency or Hospital as follows:

- Bowel & Bladder Supplies including, but not limited to, (i) urinary or indwelling catheters (other than ostomy); (ii) diapers, pads and liners; and (iii) enema bags, insertion trays and related incontinence supplies.
- Compression stockings.

- Disposable supplies that are needed for use in conjunction with durable medical equipment, such as feeding or respiratory machines.
- Medical Foods/Enteral Nutrition that are taken either orally or by nasal or abdominal tube if prescribed by a Physician due to a diagnosed injury or disease and if the patient is unable to meet his/her nutritional requirements with a normal diet.

Ostomy supplies are listed in this section under Ostomy Supplies.

The Plan does not pay Benefits for over-the counter disposable medical supplies or nutritional supplementation even if they are the same items that are listed above.

Durable Medical Equipment (DME)

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

- Ordered or provided by a Physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a Sickness, Injury or disability.
- Durable enough to withstand repeated use.
- Appropriate for use in the home.

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

Examples of DME include but are not limited to:

- Equipment to administer oxygen.
- Equipment to assist mobility, such as a standard wheelchair.
- Electric wheelchair or electric scooter may be available based on medical need and approval process.
- Hospital beds.
- Delivery pumps for tube feedings.
- Negative pressure wound therapy pumps (wound vacuums).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under Diabetes Services in this section.
- External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient

procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section.

- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are considered a Covered Health Service. Dental braces are always excluded from coverage.
- Cranial bending (helmets) that are custom molded and prescribed by a Physician.
- Shoes, shoe orthotics, shoe inserts or arch supports prescribed by a Physician.
- 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).

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

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

Note: DME is different from prosthetic devices - see *Prosthetic Devices* in this section.

Except for dedicated speech generating devices and tracheo-esophageal voice devices, benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years. Benefits for dedicated speech generating devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

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

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization from the Claims Administrator before acquiring any DME or orthotic (brace or support) that costs more than $1,000 (either retail purchase cost or cumulative retail rental cost of a single item). If prior authorization is not obtained and it is determined that the DME or orthotic was not Medically Necessary, you may be responsible for all charges.

Emergency Health Services

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

Network benefits will be paid for an Emergency admission to a non-Network Hospital as long as the Claims Administrator is notified as soon as reasonably possible after you are admitted to the non-Network Hospital. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you continue your stay in a non-Network Hospital after the date the Claims Administrator determines the transfer to a Network Hospital is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses will be determined as described under *Eligible Expenses* in Section 3, *Plan Highlights*.

Fertility Services

Therapeutic services for fertility treatment when provided by or under the direction of a Physician. Fertility services described in this section are not required to be Medically Necessary to be Covered Health Services. Except as specifically provided, covered child Dependents are not eligible for the fertility services described in this section. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART), including but not limited to InVitro fertilization (IVF). ART procedures include, but are not limited to:
  - Egg/oocyte retrieval.
  - Fresh or frozen embryo transfer.
  - Intracytoplasmic spermatozoa injection - ICSI.
  - Assisted hatching.
  - Cryopreservation and storage of embryos for 12 months.
  - Embryo biopsy for PGT-M or PGT-SR (formerly known as PGD).
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos for up to 12 months.
- Insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).
- Ovulation induction (or controlled ovarian stimulation).
- Testicular Spermatozoa Aspiration/Microsurgical Epididymal Spermatozoa Aspiration (TESA/MESA) - male factor associated surgical procedures for retrieval of spermatozoa.
- Surgical Procedures, including but not limited to: Laparoscopy, Lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, resection and ablation of endometriosis, transcervical tubal catheterization, ovarian cystectomy.
- Electroejaculation.

- Pre-implantation Genetic Testing for a Monogenic Disorder (PGT-M) or Structural Rearrangement (PGT-SR) - when the genetic parents carry a gene mutation to determine whether that mutation has been transmitted to the embryo.
- **Fertility Preservation for Medical Reasons** - when planned cancer or other medical treatment is likely to produce infertility/sterility. Coverage is limited to: collection of spermatozoa, cryopreservation of spermatozoa, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, InVitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Treatment for the diagnosis and treatment of the underlying cause of infertility is covered as described in the SPD. Benefits for diagnostic tests are described under *Scopic Procedures - Outpatient Diagnostic and Therapeutic, Office Visits*.

Benefits for certain Pharmaceutical Products, including Specialty Pharmaceutical Products, for the treatment of fertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in your home are described under *Pharmaceutical Products-Outpatient*.

Benefits for prescription drug products are described under *Outpatient Prescription Drugs*.

Enhanced Benefit Coverage

Donor Coverage: The Plan will cover associated donor medical expenses, including collection and preparation of oocyte and/or spermatozoa, and the medications associated with the collection and preparation of oocyte and/or spermatozoa. The Plan does not cover donor charges associated with compensation or administrative services.

Additional Benefit Coverage

Fertility Preservation for Non-Medical Reasons - when you would like to delay Pregnancy for non-medical reasons. Coverage is limited to: collection of spermatozoa, cryopreservation of spermatozoa, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, InVitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Fertility treatment following unsuccessful reversal of voluntary sterilization.

Fertility Treatment following the reversal of voluntary sterilization and following reversal needs to meet criteria to be eligible for Benefits (tubal reversal/reanastomosis; vasectomy reversal/vasovasostomy or vasoepididymostomy).

Criteria to be eligible for Benefits

You do not need to have a diagnosis of infertility in order to be eligible for fertility services but you must satisfy the conditions described below.

- If you are female you must be either:
  - under age 44 and using own oocytes (eggs) or donor oocytes (eggs) or

- under age 55 and using donor oocytes (eggs).

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

- If you had a voluntary sterilization you are not eligible for fertility services unless there was an unsuccessful reversal of your voluntary sterilization.

- Child Dependents are eligible only for fertility preservation but only when planned cancer or other medical treatment is likely to produce infertility/sterility.

Certain criteria to be eligible for Benefits may be waived for Fertility Preservation for medical reasons.

Benefits are limited to $20,000 per Covered Person/per lifetime(Medical) during the entire period of time the Covered Person is enrolled in Plan if the Benefits are provided at a Centers of Excellence. Benefits are limited to $10,000 per Covered Person during the entire period of time the Covered Person is enrolled in the Plan if the Benefits are provided at a facility that is not a Centers of Excellence (even if the facility is a Network facility). Covered Persons who do not live within a 60 mile radius of a Fertility Solutions Center of Excellence may contact a Fertility Solutions case manager to determine if the geographical gap exception is allowed when qualifying for an additional $10,000 lifetime maximum. Total Benefits (provided at both Centers of Excellence and facilities that are not Centers of Excellence) are limited to $20,000 per Covered Person during the entire period of time the Covered Person is enrolled in the Plan. This limit does not include Physician office visits for the treatment of Fertility for which Benefits are described under *Physician's Office Services - Sickness and Injury* below.

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

- Surgeon.
- Assistant surgeon.
- Anesthesia.
- Lab tests.
- Specific injections.

Fertility Solutions Program

We encourage you to enroll in the Fertility Solutions Program and to receive services from a Designated Provider. To enroll you can call the telephone number on your ID card or you can call the *Fertility Solutions Program Nurse Team* at 866-774-4626.

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under Mental Health Services in this SPD.
- Cross-sex hormone therapy:

- Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is provided as described under *Pharmaceutical Products – Outpatient.*
- Cross-sex hormone therapy dispensed from a pharmacy is provided as described under Section 15, *Outpatient Prescription Drugs.*

■ Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.

■ Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.

■ Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

- Bilateral mastectomy or breast reduction
- Clitoroplasty (creation of clitoris)
- Hysterectomy (removal of uterus)
- Labiaplasty (creation of labia)
- Metoidioplasty (creation of penis, using clitoris)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of urethra)
- Vaginectomy (removal of vagina)
- Vaginoplasty (creation of vagina)
- Vulvectomy (removal of vulva)

In addition to the above, the following Covered Services are also covered:

- Voice modification surgery.
- Facial feminization surgery including, but not limited to:
- Facial bone reduction.
- Face "lift".
- Facial hair removal.
- Certain facial plastic reconstruction.

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

■ A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:

- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must be 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria:
- Persistent, well-documented Gender Dysphoria.
- Capacity to make a fully informed decision and to consent for treatment.
- Must 18 years or older.
- If significant medical or mental health concerns are present, they must be reasonably well controlled.
- Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
- Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

■ The treatment plan is based on identifiable external sources including the *World Professional Association for Transgender Health (WPATH)* standards, and/or evidence-based professional society guidance.

Prior Authorization for Surgical Treatment
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization as soon as the possibility of surgery arises. If prior authorization is not obtained and it is determined that the surgery was not Medically Necessary, you may be responsible for all charges. You or your provider should also contact the Claims Administrator as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

In addition, for Non-Network Benefits, you must contact the Claims Administrator at least 24 hours before admission for a scheduled Inpatient Stay or as soon as reasonably possible for an Emergency Inpatient Stay.

It is also important that you provide notification since that will provide you with the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

Prior Authorization for Non-Surgical Treatment
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization for any scheduled (non-Emergency) health services. If prior authorization is not obtained and it is determined that the health service was not Medically Necessary, you may be responsible for all charges.

Hearing Aids

The Plan pays Benefits for hearing aids and associated testing required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring

sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased through a licensed audiologist, hearing aid dispenser, otolaryngologist or other authorized provider. Benefits are provided for the hearing aid and associated fitting charges and testing.

Benefits are also provided for certain *U.S. Food and Drug Administration (FDA)* approved over-the-counter hearing aids for Covered Persons age 18 and older who have mild to moderate hearing loss.

Benefits for over-the-counter hearing aids do not require any of the following:

- A medical exam.
- A fitting by a licensed audiologist, hearing aid dispenser, otolaryngologist, or other authorized provider.
- A written prescription or other order.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs. If you purchase a hearing aid that exceeds these minimum specifications, the Plan will treat as an Eligible Expense only the amount that the Plan would have paid for the hearing aid that meets the minimum specifications, and you will be responsible for the excess over the amount treated as an Eligible Expense, as well as any applicable deductible.

Any combination of Network Benefits and Non-Network Benefits is limited to $3,000 per hearing impaired ear every three calendar years. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 calendar years.

Note: Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories and are not subject to the coverage limits in this section. However, bone anchored hearing aids are subject to the limitations set forth in *Vision and Hearing* in Section 8, *Exclusions and Limitations*. Bone anchored hearing aids are covered only for Covered Persons who have either of the following:

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

Home Health Care

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

- Ordered by a Physician.

- Provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Not considered Custodial Care, as defined in Section 14, *Glossary*.
- Provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

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

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization as soon as the possibility of home health care services arises. If prior authorization is not obtained and it is determined that the home health care services were not Medically Necessary, you may be responsible for all charges.

Hospice Care

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

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization as soon as the possibility of inpatient hospice care arises. If prior authorization is not obtained and it is determined that the inpatient hospice care was not Medically Necessary, you may be responsible for all charges.

In addition, for Non-Network Benefits, you must contact the Claims Administrator within 24 hours of admission for an Inpatient Stay in a non- Network hospice facility.

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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

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

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

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization as soon as possible for a scheduled admission. If prior authorization is not obtained and it is determined that the Hospital admission was not Medically Necessary, you may be responsible for all charges. You or your provider should also contact the Claims Administrator as soon as is reasonably possible for non-scheduled admissions.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission in a non-Network Hospital for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Lab, X-Ray, Diagnostics and Major Diagnostics (CT, PET Scans, MRI, MRA and Nuclear Medicine) - Outpatient

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

- Lab and radiology/X-ray.
- Mammography (3D mammograms are covered).
- CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator as soon as is reasonably possible to obtain prior authorization before Genetic Testing and sleep studies are performed. If prior authorization is not obtained and it is determined that the service was not Medically Necessary, you may be responsible for all charges.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital or an Alternate Facility or on an outpatient basis in a provider's office. All services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment, treatment and procedures.
- Medication management.
- Individual, family and therapeutic group therapy.
- Crisis intervention.

The Claims Administrator determines coverage for all levels of care.

You are encouraged to contact the Claims Administrator for assistance in locating a provider and coordination of care.

Mental Health Services also include online therapy received through Talkspace. For more information on Talkspace contact the Claims Administrator.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization before scheduled (non-Emergency) inpatient services are received, including Partial Hospitalization/Day Treatment/High Intensity Outpatient and admission for services at a Residential Treatment facility. If prior authorization is not obtained and it is determined that the service was not Medically Necessary, you may be responsible for all charges. You or your provider should also contact the Claims Administrator as soon as is reasonably possible for a non-scheduled admission.

In addition, it is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization before the following services are received: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation. If prior authorization is not obtained and it is determined that the service was not Medically Necessary, you may be responsible for all charges.

Neurobiological Disorders - Autism Spectrum Disorder Services

The Plan pays Benefits for behavioral services for Autism Spectrum Disorders including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorders.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified 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 behavioral component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment, treatment and procedures.
- Medication management.
- Individual, family and group therapy.
- Crisis intervention.

The Claims Administrator provides administrative services for all levels of care.

You are encouraged to contact the Claims Administrator for assistance in locating a provider and coordination of care.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization before scheduled (non-Emergency) inpatient services are received, including Partial Hospitalization/Day Treatment/High Intensity Outpatient and admission for services at a Residential Treatment facility. If prior authorization is not obtained and it is determined that the service was not Medically Necessary, you may be responsible for all charges. You or your provider should also contact the Claims Administrator as soon as is reasonably possible for a non-scheduled admission.

In addition, it is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization before the following services are received: Intensive Outpatient Treatment programs; psychological testing; Intensive Behavioral Therapy, including *Applied Behavior Analysis (ABA)*. If prior authorization is not obtained and it is determined that the service was not Medically Necessary, you may be responsible for all charges.

Nutritional Counseling

The Plan will pay for Covered Health Services for nutritional counseling services provided in a Physician's office by an appropriately licensed or registered dietician or healthcare professional.

A medical diagnosis is not needed in order for nutritional counseling to be covered.

Benefits are limited to four individual sessions per calendar year and must be with a licensed or registered dietician. This session limit applies only to non-preventive nutritional counseling services. This session limit does not apply to nutritional counseling that is provided as part of Mental Health Services.

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when all of the following are true:

- You have a Body Mass Index (BMI) of 40 or more irrespective of comorbidities; OR you have a BMI of 35 or more with at least 1 complicating co-morbidities directly related to, or exacerbated by, obesity (morbid obesity).
- You are over the age of 21 and have minimum 5 year diagnosis of morbid obesity as documented by a physician.
- You have a 3-month physician or other health care provider supervised diet documented within the last 2 years.
- You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.

See *Bariatric Resource Services (BRS)* in *Section 7, Clinical Programs and Resources* for more information on the BRS program.

Benefits are limited to one surgery per lifetime unless there are complications to the covered surgery.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization as soon as the possibility of obesity surgery arises. If prior authorization is not obtained and it is determined that the surgery was not Medically Necessary, you may be responsible for all charges.

It is also important that you provide notification since that will provide you with the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for a scheduled Inpatient Stay and as soon as possible for an Emergency Inpatient Stay.

Ostomy Supplies

Benefits for the following ostomy supplies that are prescribed by a Physician and billed by a Physician, Home Health Care Agency or Hospital are a Covered Expense:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of

what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Depending on where the Pharmaceutical Product is administered, Benefits will be provided for administration of the Pharmaceutical Product under the corresponding Benefit category in this SPD. Benefits for medication normally available by prescription or order or refill are provided as described in Section 15, *Outpatient Prescription Drugs*. Benefits under this section do not include medications for the treatment of Fertility.

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

If you or your provider are directed to a Designated Dispensing Entity and you or your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you must use a different Pharmaceutical Product and/or prescription drug product first. You may find out whether a particular Pharmaceutical Product is subject to step therapy requirements by contacting UnitedHealthcare at www.myuhc.com or by calling the telephone number on your ID card.

UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication 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 your ID card.

The Following does not apply to the CDHP Plan

Certain Specialty Pharmaceutical Products are eligible for coupons, offers, assistance programs, or discounts (Coupons) from pharmaceutical manufacturers or affiliates that may reduce the cost for your Specialty Pharmaceutical Product. The Claims Administrator may help you determine whether your Specialty Pharmaceutical Product is eligible for this reduction. If you are eligible and redeem a Coupon from a pharmaceutical manufacturer or affiliate, your applicable deductible, and/or Coinsurance may vary (Adjusted Variable) and will be reflected as Deductible, or Coinsurance in your Explanation of Benefits. Plan payment will be determined based on the difference between the Eligible Expenses minus the Adjusted Variable described above. The redeemed Coupon value will not count toward any applicable deductible or out-of-pocket limits. Please contact **www.myuhc.com** or the telephone number on your ID card for an available list of Specialty Pharmaceutical Products.

If you choose not to participate, you will pay the applicable deductible, and/or Coinsurance as described in the Section 5, *Plan Highlights*.

Example - John is enrolled in the Health 1 option and requires a Specialty Pharmaceutical Product that is eligible for a payment assistance program from the drug manufacturer. John has not satisfied any portion of his $250 annual deductible. The Specialty Pharmaceutical Product's cost is $2,000 while the drug manufacturer offers a $500 coupon to reduce the cost. If John does not use the $500 coupon, he will be responsible for his $250 deductible and coinsurance of 10% on the remaining $1,750 ($175) meaning his total out-of-pocket amount is $425. If John uses the $500 coupon to reduce the cost to $1,500, he will be responsible for his $250 deductible and coinsurance of 10% of the remaining $1,250 ($125) reducing his total out-of-pocket amount to $375. Note that the $500 coupon does not count towards John's out-of-pocket limit.

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services provided in a Physician's office for the diagnosis 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.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

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

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing - BRCA which is ordered by the Physician. If the Genetic Testing - BRCA will be provided by a non-Network Provider, it must be authorized in advance by UnitedHealthcare so UnitedHealthcare can determine whether it is Medically Necessary.

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

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office for all Plans except for the Health 1 PPO and Health 2 PPO.

Pregnancy - Maternity Services

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.

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

- 48 hours for the mother and newborn child following a vaginal delivery.
- 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.

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

Note that Benefits will be provided for the newborn child during the 48-hour or 96-hour period only if the newborn child also qualifies as a Dependent under the Plan. (Coverage will continue beyond this timeframe if you enroll the child.)

Example – An Employee has family coverage and his wife gives birth to a child (normal birth) in April. During the 48-hour period following birth, the child is covered under the Plan. If the child is enrolled for coverage within 31 days of birth, coverage of the child continues uninterrupted from the date of birth. If the child is enrolled more than 31 days after birth but within 90 days of birth, the child will cease to be covered after the initial 48-hour period until the date of enrollment. See *When Coverage Begins* in Section 2. If the child is not enrolled within the first 90 days following birth, the Employee would need to wait until open enrollment to enroll the child.

Example – An Employee's 24 year old daughter is enrolled for coverage under the Plan. The daughter gives birth to a child (the Employee's grandchild). Since a grandchild does not qualify as a Dependent under the Plan, no Benefits will be provided for the newborn grandchild.

Prior Authorization
It is strongly recommended that you or your provider contact the Claims Administrator to obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery.

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, and have been proven to have a beneficial effect on health outcomes. Preventive care services do not have to be Medically Necessary to be Covered Health Services. The following are covered as Preventive care services by the Plan no later than 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.* http://www.uspreventiveservicestaskforce.org/
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. http://www.cdc.gov/
- 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.* http://www.hrsa.gov/
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.* http://www.hrsa.gov/

You can access the current list of Preventive care services that are covered by the Plan at http://www.uhcpreventivecare.com/ or by calling 1-888-651-7322.

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. You can obtain additional information on how to access Benefits for breast pumps by going to **www.myuhc.com** or by calling the number on your ID card. 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 5, *Plan Highlights*, under *Covered Health Services*.

A 3D mammogram will be covered as a Preventive care service in the same manner as a regular mammogram. Only one mammogram (whether it be a regular mammogram or a 3D mammogram) will be covered as a Preventive care service during a calendar year.

If more than one breast pump can meet your needs, Benefits are available only for the most Cost-Effective pump. UnitedHealthcare 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.

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

In addition to the services listed above, this Preventive care Benefit includes certain:

- Routine lab tests.
- Diagnostic consults to prevent disease and detect abnormalities.
- Diagnostic radiology and nuclear imaging procedures to screen for abnormalities.
- Breast cancer screening and genetic testing.
- Tests to support cardiovascular health.
- Vision screenings which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment).
- Eyeglasses/lenses only as required after cataract surgery.

These additional services are paid under the Preventive care Benefit when billed by your provider with a wellness diagnosis. Call the number on your ID card for additional information regarding coverage available for specific services.

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

Private Duty Nursing - Outpatient

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

Prior Authorization
It is strongly recommended that you or your provider obtain prior authorization from the Claims Administrator five business days before receiving private duty nursing services or as soon as is reasonably possible. If prior authorization is not obtained and it is determined that the services were not Medically Necessary, you may be responsible for all charges.

Prosthetic Devices

Benefits are paid by the Plan for external prosthetic devices that replace a limb or body part limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, 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.

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

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

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

Benefits 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.

Note: This does not address internal devices such as pacemakers, implantable cardioverter defibrillators and electrophysiology implant. These implantable devices are under Lab, X-Ray and Major Diagnostics - Outpatient benefit.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization before acquiring any prosthetic that costs more than $1,000. If prior authorization is not obtained and it is determined that the prosthetic was not Medically Necessary, you may be responsible for all charges.

Reconstructive Procedures

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

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an

existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the *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 other Covered Health Service. You can contact UnitedHealthcare at the number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a reconstructive procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

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.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization before scheduled (non-Emergency) reconstructive procedures. If prior authorization is not obtained and it is determined that the reconstructive procedure was not Medically Necessary, you may be responsible for all charges. You or your provider should also contact the Claims Administrator as soon as is reasonably possible for any non-scheduled reconstructive procedure (including an Emergency reconstructive procedure).

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services (including habilitative services) limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative treatment.
- Speech therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy following a post-traumatic brain Injury or stroke.

- Vision therapy.
- Pulmonary rehabilitation.
- Cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program to maintain a Covered Person's current condition or to prevent or slow further decline.
- The services are ordered by a Physician and provided and administered by a licensed provider.
- The services 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.
- The services require clinical training in order to be delivered safely and effectively.
- The services are not Custodial Care.

The Claims Administrator will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition 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 or Physician.
- 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, educational/vocational training and Residential Treatment are not habilitative services. A service or treatment plan that does not help the Covered Person to meet functional goals is not a habilitative service.

The Plan may require the following be provided:

- medical records.

- other necessary data to allow the Plan to prove medical treatment is needed.

When the treating provider expects that continued treatment is or will be required to allow the Covered Person to achieve progress, the Claims Administrator may request additional medical records.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

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 disorder.

The following limits apply:

- 35 visits per calendar year for physical therapy.
- 25 visits per calendar year for occupational therapy.
- 25 visits per calendar year for speech therapy
- Unlimited visits per calendar year for pulmonary rehabilitation therapy.
- Unlimited visits per calendar year for cardiac rehabilitation therapy.
- Unlimited visits per calendar year for cognitive rehabilitation therapy.
- 25 visits per calendar year for Manipulative Treatment.
- Unlimited visits per calendar year for vision therapy.
- Unlimited visits per calendar year for post-cochlear implant aural therapy.
- Massage therapy only in conjunction with occupational therapy, physical therapy and Manipulative Treatment.

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

Physical therapy, Occupational therapy and Speech therapy visit limits do not apply to Autism diagnosis.

Reproduction

The Plan pays for reversal of voluntary sterilization. There is no requirement that it be Medically Necessary.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

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

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

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

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

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

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

Benefits are available only if both of the following are true:

- The initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost-effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled 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 dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization as soon as possible before a scheduled admission. If prior authorization is not obtained and it is determined that the admission was not Medically Necessary, you may be responsible for all charges. You or your provider should also contact the Claims Administrator as soon as is reasonably possible for any non-scheduled admission.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility. All services must be provided by or

under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment/High Intensity Outpatient.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Inpatient treatment and Residential Treatment includes room and board in a Semi-private Room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment, treatment and procedures.
- Medication management.
- Individual, family and group therapy.
- Crisis intervention.

The Claims Administrator determines coverage for all levels of care.

You are encouraged to contact the Claims Administrator for assistance in locating a provider and coordination of care.

Substance-Related and Addictive Disorder Services also include online therapy received through Talkspace. For more information on Talkspace contact the Claims Administrator.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization before scheduled (non-Emergency) inpatient services are received, including Partial Hospitalization/Day Treatment/High Intensity Outpatient and admission for services at a Residential Treatment facility. If prior authorization is not obtained and it is determined that the service was not Medically Necessary, you may be responsible for all charges. You or your provider should also contact the Claims Administrator as soon as is reasonably possible for any non-scheduled services.

In addition, it is strongly recommended that you or your provider contact the Claims Administrator to obtain prior authorization before the following outpatient services are received: Intensive Outpatient Treatment programs; psychological testing. If prior authorization is not obtained and it is determined that the service was not Medically Necessary, you may be responsible for all charges.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

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

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization as soon as possible for scheduled surgery. If prior authorization is not obtained and it is determined that the surgery was not Medically Necessary, you may be responsible for all charges. You or your provider should also contact the Claims Administrator as soon as is reasonably possible for any non-scheduled surgery (including Emergency surgery).

Therapeutic Treatments - Outpatient

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

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

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

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.

- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization as soon as possible for scheduled services. If prior authorization is not obtained and it is determined that the service was not Medically Necessary, you may be responsible for all charges. You or your provider should also contact the Claims Administrator as soon as is reasonably possible for any non-scheduled services (including Emergency services).

Transplantation Services

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

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

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

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

Transplantation services include evaluation for transplant, organ procurement and donor searches. Transplantation procedures may be received at a Centers of Excellence, a Network facility that is not a Centers of Excellence or a non-Network facility.

Prior Authorization
It is strongly recommended that you or your provider notify the Claims Administrator to obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If prior authorization is not obtained and it is determined that the service was not Medically Necessary, you may be responsible for all charges.

In addition, for Non-Network Benefits, you must contact the Claims Administrator 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.

Support in the event of serious illness
If you or a covered family member needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury*.

Urinary Catheters

Benefits for external, indwelling and intermittent urinary catheters for incontinence or retention.

Benefits include related urologic supplies for indwelling catheters limited to:

- Urinary drainage bag and insertion tray (kit).
- Anchoring device.
- Irrigation tubing set.

Wigs

The Plan pays Benefits for wigs when the hair loss is due to cancer treatments.

Any combination of Network Benefits and Non-Network Benefits is limited to $500 per lifetime.

SECTION 7 - CLINICAL PROGRAMS AND RESOURCES

What this section includes:
Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools.
- Disease Management Services.
- Complex Medical Conditions Programs and Services.
- Wellness Programs.
- Women's Health/Reproductive.

Erie Insurance believes in giving you the tools you need to be an educated health care consumer. To that end, Erie Insurance 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: you may have access to certain mobile apps for personalized support to help live healthier. Please call the number on your ID card or visit **www.myuhc.com** for additional information.

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 Erie Insurance 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

NurseLine℠

NurseLine℠ is a 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 or access this service online, a registered nurse may refer you to any additional resources that Erie Insurance has available to help you improve your health and well-being or manage a chronic condition. Contact NurseLine℠ 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 Drug Products safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLine[SM] gives you another convenient way to access health information. By calling the NurseLine[SM], you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLine[SM] is available to you at no cost. To use this convenient service, simply call the number on your ID card or log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. If you access NurseLine[SM] online 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 calling NurseLine[SM].

Your child is running a mild fever and it's 1:00 AM. What do you do?
Call NurseLine[SM] any time, 24 hours a day, seven days a week. You can count on NurseLine[SM] to help answer your health questions.

Health Survey

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

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

If you need any assistance with the online survey, please call the number on your ID card.

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.
- Pediatric and adolescent immunizations.
- Cervical cancer screenings for women.
- Comprehensive screenings for individuals with diabetes.
- Influenza/pneumonia immunizations for enrollees.

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

Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease; and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Second Opinion Service

The Plan offers a voluntary second opinion education service, which is a live interactive video experience, powered by 2nd.MD. A dedicated nurse will oversee medical records collection, selection, and scheduling with a post-consultation support.

For additional information regarding the program, please contact the 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[SM] 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 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 Management Services

Disease Management Services

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

educational information. You may also be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- Educational materials that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications.
- Access to educational and self-management resources on a consumer website.
- An opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care.
- Access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - Education about the specific disease and condition.
  - Medication management and compliance.
  - Reinforcement of on-line behavior modification program goals.
  - Preparation and support for upcoming Physician visits.
  - Review of psychosocial services and community resources.
  - Caregiver status and in-home safety.
  - Use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on your ID card.

Livongo® Diabetes Management Program

The Livongo®. Diabetes Management Program is provided through Teledoc Health and is provided at no cost to Covered Persons who are living with diabetes. When you enroll in the program you will receive:

A cellular-connected blood glucose meter

Unlimited test strips and lancets shipped to you.

24/7 real-time support for out-of-range readings

Access to expert coaches to assist you with managing your diabetes.

If you have questions about the program or your eligibility to participate in it, you may call Livongo Member Support at 1-800-945-4355 or visit **join.livongo.com.**

Virta Virtual Weight-Loss Clinic

Virta is a virtual weight-loss clinic that is available at no cost to a Covered Person who is age 18 or older and who has certain metabolic health conditions. With Virta you will have a

dedicated care team that will build a personalized nutrition therapy care plan so that you can lose weight and keep the weight off. The personalized nutrition therapy care plan can include nutrition therapy, weight loss medications or a combination of both. To see if you qualify for Virta go to www.virtahealth.com/join/Erie, click on "Get Started" and complete your application.

Complex Medical Conditions Programs and Services

Bariatric Resource Services (BRS)

The Plan offers UnitedHealthcare's Bariatric Resource Services (BRS) program. The BRS program provides:

- Specialized clinical consulting services to covered Employees and Enrolled Dependents to educate them on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.
- You can access the Bariatric Resource Services program by calling the number on your ID card.
- See *Obesity Surgery* in Section 6, *Additional Coverage Details* for obesity surgery requirements.

If you obtain obesity surgery through the Bariatric Resource Services program, you may be eligible for Travel and Lodging assistance. For more information, please refer to the *Travel and Lodging Assistance Program* described below.

Cancer Resource Services (CRS) Program

The Plan offers UnitedHealthcare's Cancer Resource Services (CRS) program to provide you with access to information and member assistance through a team of specialized cancer nurse consultants and access to one of the nation's leading cancer programs. Participation in the program is voluntary and without extra charge.

To learn more about CRS, visit www.myoptumhealthcomplexmedical.com or call the number on your ID card or call the program directly at 1-866-936-6002.

If you obtain cancer treatment through the Cancer Resource Services program, you may be eligible for Travel and Lodging assistance. For more information, please refer to the *Travel and Lodging Assistance Program* described below.

Cancer Support Program

UnitedHealthcare offers a program that provides support to a Covered Person who has cancer. You have the opportunity to engage with a nurse that specializes in cancer, education and guidance throughout your care path. You may also call the program and speak with a nurse whenever you need to. This nurse will be a resource and advocate to help you manage your condition. This program will work with you and your Physicians, as appropriate, to offer support and education on cancer, and self-care strategies and treatment options.

Participation is voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the Cancer Support Program, please call the number on your ID card or call the program directly at 1-866 936-6002.

Kidney Resource Services (KRS) program
End-Stage Renal Disease (ESRD)

The Kidney Resource Services program is a voluntary program that provides Covered Persons with access to a registered nurse advocate who specializes in helping individuals live with kidney disease. As a participant in the KRS program, you'll work with a nurse who will provide you with support and information. The nurse can help you manage other conditions, such as diabetes and high blood pressure. The nurse can also help you find doctors, specialists and dialysis centers. This program is available at no extra cost to you.

With KRS, you have access to a registered nurse who specializes in kidney health. This program is designed to help you be your own best advocate for your health. You may have been referred to the KRS program by your medical provider or from past claim information. As part of your health benefits, it's available at no extra cost to you.

KRS nurse advocates are available, Monday through Friday toll-free at 1-866-561-7518 (TTY: 711).

Coverage for dialysis and kidney-related services are described in other sections of this SPD.

Congenital Heart Disease (CHD) Resource Services

UnitedHealthcare offers a program that provides support to a Covered Person who has Congenital Heart Disease (CHD) through all stages of treatment and recovery. This program will work with you and your Physicians, as appropriate, to offer support and education on CHD. Program features include clinical management by specialized CHD Nurses, support from specialized Social Workers, assistance with choosing Physicians and Facilities, and access to Designated Providers. Participation in CHD Resource Services is voluntary and without extra charge.

To learn more about CHD Resource Services program, visit **www.myoptumhealthcomplexmedical.com** or call UnitedHealthcare at the number on your ID card or you can call the CHD Resource Services Nurse Team at 888-936-7246.

If you are considering any CHD surgeries you must contact CHD Resource Services prior to surgery to enroll in the program in order for the surgery to be eligible for the benefits provided by CHD Resource Services.

If you obtain surgery through CHD Resource Services, you may be eligible for Travel and Lodging assistance. For more information, please refer to the *Complex Medical Conditions Travel and Lodging Assistance Program* described below.

Transplant Resource Services (TRS) Program

The Transplant Resource Services (TRS) program provides you with access to one of the nation's leading transplant programs. Receiving transplant services through this program means your transplant treatment is based on a "best practices" approach from health care

professionals with extensive expertise in transplantation. Participation in the Transplant Resource Services Program is voluntary and without additional charge.

To learn more about Transplant Resource Services, visit **www.myoptumhealthcomplexmedical.com** or call the number on your ID card.

If you obtain transplant services through the Transplant Resource Services Program, you may be eligible for Travel and Lodging assistance. For more information, please refer to the *Complex Medical Conditions Travel and Lodging Assistance Program*, described below.

Specialist Management Solutions Program

Specialist Management Solutions is a program that provides guidance and options for both conservative and surgical care as well as access to networks of ambulatory surgery centers and designated providers to help support a positive journey and better health outcomes.

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

In certain situations, the Plan provides travel and lodging assistance. For more information on *Complex Medical Conditions Travel and Lodging Assistance Program*, refer to the provision below.

Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services described below.

The travel and lodging Benefit is only available for a Covered Person who meets the qualifications for the Benefit, including receiving care at a Centers of Excellence or Designated Provider for care of the following:

- Obesity surgery through the Bariatric Resource Services program
- Cancer treatment
- Congenital heart disease treatment
- Transplant treatment
- Specialist Management Solutions Program

Eligible expenses are reimbursed after the expense forms have been completed and submitted with the appropriate receipts. If you have specific questions regarding the travel and lodging Benefit, please call UnitedHealthcare at 1-888-651-7322.

Requirements for Reimbursement

The Plan will reimburse certain meal, travel and lodging expenses for the Covered Person and one companion (two companions, if the Covered Person is under age 18), provided the Covered Person is not covered by Medicare. Reimbursement is subject to the following:

- If treatment is at a Centers of Excellence, the Centers of Excellence at which treatment is provided must be at least 75 miles from the Covered Person's residence. If treatment

is at a Designated Provider for an Orthopedic Health Support surgery, the Designated Provider must be at least 50 miles from the Covered Person's residence.

- The maximum amount that will be reimbursed per day is $125 if treatment is at a Centers of Excellence less than 200 miles from the Covered Person's residence or treatment is at a Designated Provider. The maximum amount that will be reimbursed per day is $250 if treatment is at a Centers of Excellence at least 200 miles from the Covered Person's residence.
- The maximum reimbursement for treatment at a Centers of Excellence is $3,000 for a calendar year for the Covered Person. The maximum reimbursement for a Specialist Management Solutions Program at a Designated Provider is $2,000 per occurrence (surgery).
- If the Covered Person is enrolled in the CDHP option, reimbursement will only be made once the applicable deductible has been satisfied.
- Reimbursement will only be made for eligible expenses (as described below) for which appropriate proof of payment, such as itemized receipts and proof of mileage from online driving directions (such as Mapquest or Google Maps), and a properly completed claim form are submitted to UnitedHealthcare. All claims for reimbursement must be submitted by December 31st of the calendar year following the calendar year in which the expenses were incurred.

Reimbursable Travel, Meals and Lodging Expenses

- Airfare for the Covered Person and one companion (up to two companions if the Covered Person is under age 18) at economy or coach rate.
- Train, bus, subway and taxi fares (not including limos or car services) for the Covered Person and one companion (up to two companions if the Covered Person is under age 18).
- If the Covered Person is driven to the Centers of Excellence or Designated Provider in a private automobile, mileage reimbursement at the standard IRS mileage rate for the most direct route between the Covered Person's residence and the Centers of Excellence or Designated Provider.
- Parking and tolls.
- Overnight lodging for the Covered Person and one companion (up to two companions if the Covered Person is under age 18).
- Meals purchased for the Covered Person and one companion (up to two companions if the Covered Person is under age 18) at a restaurant, diner, cafeteria or other establishment that serves prepared food. Only the cost of the meal and non-alcoholic beverages plus gratuities up to 20 percent is eligible for reimbursement.
- Food and non-alcoholic beverages for the Covered Person and one companion (up to two companions if the Covered Person is under age 18) that is purchased at a grocery store.

Non-Reimbursable Expenses

Any expenses other than those listed above are not eligible for reimbursement. Examples of items that are not eligible include (but are not limited to):

- Alcoholic beverages.
- Personal or cleaning supplies.
- Over-the-counter dressings or medical supplies.
- Deposits.
- Utilities and furniture rental, when billed separate from the rent payment.
- Phone calls, newspapers, or movie rentals.

Wellness Programs

Tobacco Cessation Program

UnitedHealthcare provides a tobacco cessation program to help tobacco users withdraw from nicotine dependence. The Quit For Life® program employs an evidence-based combination of physical, psychological and behavioral strategies to help enable you to take responsibility for and overcome your addiction to tobacco use.

If you are a tobacco user, the Quit For Life® program tailors a quitting plan for you and incorporates the following components:

- Multiple planned phone-based coaching sessions.
- Unlimited access to Quit Coach® staff for ongoing support for the duration of your program via toll-free phone and live chat.
- Nicotine replacement therapy (patch or gum) sent to you in conjunction with your quit date.
- Unlimited access to a mobile-friendly online web portal, including support tools that complement your phone-based coaching.
- An online Quit Guide designed to complement your phone-based coaching sessions and web activity.
- Tailored motivational emails sent throughout your quitting process.
- Personalized, interactive text messages.

If you would like to enroll in Quit For Life®, or if you would like additional information regarding the program and also how to access the program online, please call the number on your ID card.

Women's Health/Reproductive

Fertility Solutions

Fertility Solutions is a program administered by the Claims Administrator or its affiliates made available to you by the Plan Sponsor. The Fertility Solutions program provides:

- Specialized clinical consulting services to covered Employees and enrolled Dependents to educate on fertility treatment options.
- Access to Designated Providers (specialized Network facilities and Physicians) for fertility services.
- Education, specialized clinical counseling, treatment options and access to a national Network of premier fertility treatment clinics.

Covered Persons who do not live within a 60 mile radius of a Fertility Solutions Designated Provider will need to contact a Fertility Solutions case manager to determine a Designated Provider prior to starting treatment.

For fertility services and supplies to be considered Covered Health Services through this program, you must contact Fertility Solutions and enroll with a nurse consultant prior to receiving services.

You or a covered Dependent may:

- Be referred to Fertility Solutions by the Claims Administrator.
- Call the telephone number on your ID card.
- Call Fertility Solutions directly at 1-866-774-4626.

To take part in the Fertility Solutions program, call a nurse at 1-866-774-4626. The Plan will only pay Benefits under the Fertility Solutions program if Fertility Solutions provides the proper notification to the Designated Provider performing the services (even if you self-refer to a provider in that Network).

Use of a Centers of Excellence (COE) is encouraged but is not mandated. Where aa COE is used, the lifetime maximum is $20,000 (instead of $10,000) even if the Fertility Solutions Program is not used

SECTION 8 - EXCLUSIONS AND LIMITATIONS: 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*.

Services, supplies and treatments that are not Medically Necessary are not covered unless it is specifically provided in this SPD that the service, supply or treatment is covered regardless of whether it is Medically Necessary (for example, *Preventive Care Services* as described in Section 6, *Additional Coverage Details*). For this reason, it is strongly recommended that you or your provider notify the Claims Administrator beforehand for scheduled (non-Emergency) services, supplies or treatment. When notified in advance, the Claims Administrator can determine whether the service, supply or treatment is Medically Necessary before you incur it.

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

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 intended to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD will specifically state that the list "is limited to."

Alternative Treatments

1. Acupressure.

2. Aromatherapy.

3. Hypnotism.

4. Massage therapy, except as described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*.

5. Rolfing (soft tissue manipulation).

6. Art therapy, music therapy, dance therapy, animal-assisted therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative*

Medicine (NCCAM) of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

7. Wilderness, adventure, camping, outdoor, or other similar programs.

Dental

1. Dental care, which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

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, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressives drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

This exclusion does not apply to anesthesia that is required to perform dental care on a covered child under age 5 or a covered disabled Dependent.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Extractions (including wisdom teeth, except for bony-impacted wisdom teeth as described under *Dental Services – Accident Only* in Section 6, *Additional Coverage Details*), restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement and which are set forth on the current list of preventive care services. See *Preventive Care Services* in Section 6, *Additional Coverage Details*. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. Dental implants, bone grafts, and other implant-related procedures.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

4. Dental braces (orthodontics).

5. Treatment of congenitally missing, malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly.

6. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature, including oral appliances.

Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.

2. Orthotic appliances and devices that straighten or re-shape a body part, except as described under Durable Medical Equipment (DME) in Section 6, Additional Coverage Details. This exclusion does not apply to cranial molding helmets and cranial banding.

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics and some types of braces, including orthotic braces available over-the-counter. This exclusion does not apply to diabetic footwear for Covered Persons with diabetic foot disease for which Benefits are described under *Diabetic Services* in Section 6, *Additional Coverage Details*.

3. The following items are excluded, even if prescribed by a Physician:

- Blood pressure cuff/monitor.
- Enuresis alarm.
- Non-wearable external defibrillator.
- Trusses.
- Ultrasonic nebulizers.

4. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.

5. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

6. Devices and computers to assist in communication and speech except for dedicated speech generating devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

7. Oral appliances for snoring.

8. Powered and non-powered exoskeleton devices.

Pharmaceutical Products

The exclusions listed below apply to Pharmaceutical Products that are covered under the medical portion of the Plan only. Prescription drug coverage is described in Section 15, *Outpatient Prescription Drugs* and includes its coverage details and exclusions.

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. Please refer to Section 15, *Outpatient Prescription Drugs* for coverage and exclusions for prescription drugs for outpatient use.

2. Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to Covered Persons for self-infusion.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.

4. Over-the-counter drugs and treatments.

5. Growth hormone therapy.

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

   This exclusion does not apply if you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment). If you have a life-threatening Sickness or condition, under such circumstances, Benefits may be available for the New Pharmaceutical Product to the extent provided for in Section 6, *Additional Coverage Details*.

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

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded, unless the Plan specifically covers the services. The fact that an Experimental or Investigational or 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.

Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses.

   - Nail trimming, nail cutting, or nail debridement.

2. Hygienic and preventive maintenance foot care. Examples include:

   - Cleaning and soaking the feet.
   - Applying skin creams in order to maintain skin tone.

   This exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic or peripheral vascular disease.

3. Treatment of flat feet.

4. Treatment of subluxation of the foot.

5. Shoe inserts, unless prescribed as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

6. Arch supports, unless prescribed as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

7. Shoes (standard or custom), lifts and wedges, unless prescribed as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

8. Shoe orthotics, unless they are custom molded and prescribed as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

Gender Dysphoria

Cosmetic Procedures that are not covered as described under *Gender Dysphoria* in Section 6, *Additional Coverage Details*.

Medical Supplies and Equipment

1. Prescribed or non-prescribed medical supplies. Examples:

   - Over-the-Counter compression stockings, ace bandages, gauze and dressings.

   This exclusion does not apply to:

   - Ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
   - Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment (DME) in* Section 6, *Additional Coverage Details*.
   - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.

- Urinary catheters for which Benefits are provided as described under *Urinary Catheters* in Section 6, *Additional Coverage Details*.

2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*.

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

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

1. Services performed in connection with conditions not classified in the current edition of the International Classification of Diseases section on Mental, Behavioral and Neurodevelopmental Disorders or *Diagnostic and Statistical Manual of the American Psychiatric Association*.

2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, pyromania, kleptomania, gambling disorder and paraphilic disorders.

4. Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.

5. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.

6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.

7. Transitional Living services (including recovery residences).

8. Non-medical 24-hour withdrawal management, providing 24-hour supervision, observation, and support for Covered Persons who are intoxicated or experiencing withdrawal, using peer and social support rather than medical and nursing care.

9. Residential care for Covered Persons with substance-related and addictive disorders who are unable to participate in their care due to significant cognitive impairment.

Nutrition

1. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition-based therapy. Examples include supplements,

electrolytes and foods of any kind (including high protein foods and low carbohydrate foods).

2. Nutritional counseling for either individuals or groups, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to services described under *Diabetes Services* or under *Nutritional Counseling* in Section 6, *Additional Coverage Details*. This exclusion also does not apply to preventive care for which Benefits are provided under *Preventive Services* in Section 6, *Additional Coverage Details*. Further, this exclusion also does not apply nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:

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

3. Food of any kind, except as under *Disposable Medical Supplies* in Section 6, *Additional Coverage Details*. Examples of foods that are not covered include:

   - Enteral feedings and other nutritional and electrolyte formulas, including donor breast milk, except for medical foods/enteral nutrition as described under *Disposable Medical Supplies* in Section 6, *Additional Coverage Details*. Infant formula available over the counter is always excluded.
   - Foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes.
   - Oral vitamins and minerals, except as otherwise prescribed by a physician.
   - Meals you can order from a menu, for an additional charge, during an Inpatient Stay.
   - Other dietary and electrolyte supplements.

4. Health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes. This exclusion does not apply to any smoking cessation program offered by the Plan as a reasonable alternative in order to obtain a waiver of the tobacco user surcharge.

Personal Care, Comfort or Convenience

1. Television.

2. Telephone.

3. Beauty/barber service.

4. Guest service.

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

   - Air conditioners, air purifiers and filters and dehumidifiers.
   - Batteries and battery chargers.

- Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement;
- Car seats.
- Chairs, bath chairs, feeding chairs, toddler chairs, ergonomically correct chairs, chair lifts and recliners.
- Exercise equipment and treadmills.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Medical alert systems.
- Motorized beds, non-Hospital beds, comfort beds and mattresses.
- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

Physical Appearance

1. Cosmetic Procedures. See the definition in Section 14, *Glossary*. Examples include:

    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple. This exclusion does not apply to liposuction for which Benefits are provided as described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.
    - Pharmacological regimens, nutritional procedures or treatments.
    - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Sclerotherapy treatment of veins.
    - Hair removal or replacement by any means, except for hair removal as described under *Gender Dysphoria* in Section 6, *Additional Coverage Details*.
    - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
    - Treatment for spider veins.
    - Skin abrasion procedures performed as a treatment for acne.
    - Treatments for hair loss.
    - Varicose vein treatment of the lower extremities when it is considered cosmetic.

2. Replacement of an existing intact 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, health club memberships and programs, spa treatments and diversion or general motivation.

4. Weight loss programs whether or not they are under medical supervision or for medical reasons. This exclusion does not apply to the medical treatment of morbid obesity.

5. Wigs and other scalp hair prosthesis except when the hair loss is due to cancer treatments.

6. Treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. Biofeedback.

2. Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

3. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.

4. Speech therapy to treat stuttering, stammering, or other articulation disorders without the treatment or diagnosis of Autism Spectrum Disorders.

5. Speech therapy, except when required for treatment of a speech impairment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*.

6. Psychosurgery (lobotomy).

7. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings. **This exclusion does not apply to (i) any smoking cessation program that is a preventive care service, (ii) the Quit For Life tobacco cessation program described in Section 7 or (iii) any smoking cessation program that is provided as a reasonable alternative in order for you to obtain a waiver of the tobacco user surcharge** (see Section 3, *Tobacco User Surcharge*)**.** For more information, contact UnitedHealthcare or the Benefits Operations & Planning Section of Erie Insurance.

8. Chelation therapy, except to treat heavy metal poisoning.

9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.

10. The following treatments for obesity:

    - Non-surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*.
    - Surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in Section 6, *Additional Coverage Details*.

11. Medical and surgical treatment of excessive sweating (hyperhidrosis).

12. Treatment of temporomandibular joint syndrome (TMJ. (Diagnosis only is covered.)

13. Breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

14. Habilitative services or therapies for the purpose of general well-being or condition in the absence of a disabling condition.

15. Intracellular micronutrient testing.

16. Cellular and Gene Therapy services unless received from a Designated Provider.

Providers

1. Services performed by a provider who is a family member by birth or marriage, including your 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 ordered or delivered by a Christian Science practitioner.

4. Services performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.

5. 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.
- Is not actively involved in your medical care after the service is received.

This exclusion does not apply to emergency room services or urgent care services. This exclusion does not apply to mammography.

Reproduction

1.The following infertility treatment-related services:

- Cryo-preservation and other forms of preservation of reproductive materials except as described under *Fertility Services* in Section 6, *Additional Coverage Details*.
- Long-term storage (greater than 12 months) of reproductive materials such as spermatozoa, eggs, embryos, ovarian tissue, and testicular tissue.

2. The following services related to donor services for donor spermatozoa, ovum (egg cell) or oocytes (eggs), or embryos (fertilized eggs):

- Purchased egg donor (i.e., clinic or egg bank) – The cost of donor eggs. This refers to purchasing a donor egg that has already been retrieved and is frozen.
- Purchased donor spermatozoa (i.e., clinic or spermatozoa bank) – The cost of procurement and storage of donor spermatozoa. This refers to purchasing donor spermatozoa that has already been obtained and is frozen or choosing a donor from a database.
- Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
- All costs associated with surrogate motherhood; in vitro fertilization (IVF) for a traditional Surrogate; non-medical costs associated with a gestational carrier.
- Ovulation predictor kits.

3. Surrogate parenting, donor oocytes (eggs), donor spermatozoa and host uterus.

4. Assisted Reproductive Technology procedures done for non-genetic disorder sex selection or eugenic (selective breeding) purposes.

5. Fertility services for a Covered Person with a voluntary sterilization in place unless there has been an unsuccessful reversal of the sterilization. Fertility services for a Covered Person (i) who has a diagnosis of cancer and is planning cancer treatment or (ii) who is obtaining medical treatment for any condition that is demonstrated to result in infertility, except as specified as a covered service under fertility preservation in Section 6, *Additional Coverage Details* under *Fertility Services*.

6. Infertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation).

7. Pre-implantation Genetic Testing for Aneuploidy (PGT-A) used to select embryos for transfer in order to increase the chance for conception.

Services Covered under Another Plan

Services for which coverage is available:

1. Under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB).*

2. Under workers' compensation, no-fault automobile coverage or similar legislation if you could elect such coverage, or could have such coverage elected for you.

3. While on active military duty.

4. For treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably available to you.

5. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

Transplants

1. Health services for organ and tissue transplants except as identified under *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 for transplants involving animal organs.

3. 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.)

Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even if ordered by a Physician, except as identified under *Complex Medical Conditions Travel and Lodging Assistance Program for the Covered Health Services* in Section 7, *Clinical Programs and Resources.*

   This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details.*

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care.

2. Domiciliary Care, as defined in Section 14, *Glossary.*

3. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.

4. Private Duty Nursing received on an inpatient basis.

5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*.

6. Rest cures.

7. Services of personal care attendants.

8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. Routine vision examinations, including refractive examinations to determine the need for vision correction.

2. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).

3. Purchase cost and associated fitting charges for eyeglasses or contact lenses, except for after cataract surgery, as described under *Preventive Care Services* in Section 6, *Additional Coverage Details*.

4. Bone anchored hearing aids except when either of the following applies:

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

   The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions.

5. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. Autopsies and other coroner services and transportation services for a corpse.

2. Charges for:

   - Missed appointments.

- Room or facility reservations.
- Completion of claim forms.
- Record processing.

3. Charges prohibited by federal anti-kickback or self-referral statutes.

4. Diagnostic tests that are:

   - Delivered in other than a Physician's office or health care facility.
   - Self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests.

5. Expenses for health services and supplies:

   - That are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
   - That are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends.
   - For which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
   - That exceed Eligible Expenses or any specified limitation in the Plan.
   - For which a non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts.

6. Foreign language and sign language services.

7. Long term (more than 30 days) storage of blood, umbilical cord or other material. This exclusion does not apply to the storage of reproductive materials as described in *Fertility Services* in Section 6, *Additional Coverage Details*.

8. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

   - Medically Necessary (unless specifically provided otherwise).
   - Described as a Covered Health Service in this SPD under Section 6, *Additional Coverage Details* and in Section 5, *Plan Highlights*.
   - Not otherwise excluded in this SPD under this Section 8, *Exclusions and Limitations*.

9. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

10. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:

    - Required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration.
    - 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*.
    - Related to judicial or administrative proceedings or orders.
    - Required to obtain or maintain a license of any type.

11. In the event a non-Network provider waives a Copayment, Coinsurance and/or any deductible, no Benefits are provided for the health care service.

12. Health care services from a Non-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, freestanding facility, residential treatment facility, Inpatient Rehabilitation Facility, and Skilled Nursing Facility received outside of the Covered Person's state of residence. For the purpose of this exclusion the "state of residence" is the state where the Covered Person is a legal resident, plus any geographically bordering adjacent state or, for a Covered Person who is a student, the state where they attend school during the school year.

    This exclusion does not apply in the case of an Emergency or when there is no Network provider who is reasonably accessible or available to provide Covered Health Services

SECTION 9 - CLAIMS PROCEDURES

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

By submitting a claim for benefits, you (or your provider, if your provider submits the claim) certify that the service or drug provided was provided legally and, in the case of a drug, that the drug was or will be used legally.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, the Network provider will file your claim and the Plan will pay the Physician or facility directly. If you have met your Annual Deductible and 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 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 Product when you fill it and you believe that the Plan should have paid for it.
- You pay a Copay and/or Coinsurance and you believe that the amount you paid 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 claim for Benefits as described in this section.

If Your Non-Network Provider Does Not File Your Claim

If your non-Network provider does not file your claim, you will need to file the claim. You can obtain a claim form by visiting **www.myuhc.com**, calling the toll-free number on your ID card or contacting the Benefits Operations & Planning Section of Erie Insurance. 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 Employee.
- 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.
- A statement indicating either that the patient is or is not enrolled for coverage under any other health plan or program. If the patient is enrolled for coverage under another health plan or program, you will need to include the name and address of the other plan(s) and the insurance carrier(s) and administrator(s).
- 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.
  - The name of the patient

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, your claims should be submitted to:

Optum Rx Claims Department
PO Box 650334
Dallas, TX 75265-0334

After your claim is processed, 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.

Payment of Benefits

The Plan prohibits assignments of benefits. All rights to benefits under the Plan are personal to you. Your rights and benefits under the Plan cannot be assigned, sold, pledged, or transferred to a third party, including, but not limited to a non-Network provider. This includes the right to payment or reimbursement for benefits under the Plan and the right to file a lawsuit to recover benefits due under the Plan. Any purported assignment of rights or benefits is void and will not be recognized by the Plan.

The Claims Administrator, in its discretion, may issue payments directly to providers for covered services (whether or not pursuant to an authorization); provided, however, that the

Claims Administrator will have the Plan make payments directly to non-Network providers to the extent required by the *No Surprises Act*. Direct payment to a provider by the Claims Administrator shall not be deemed to create an assignment of benefits and it will not constitute a waiver of the application of this provision. When the Claims Administrator in its discretion directs payment to a provider, you remain the sole beneficiary of the payment and the provider does not thereby become a beneficiary of the Plan.

The prohibition of assignments does not take away your ability to designate an authorized representative to file claims for benefits or to file appeals as part of the Plan's internal claims and appeals process. In order to appoint an authorized representative, you must follow the process established by the Claims Administrator, provided that if your claim is an "urgent care claim", as described below in *Claim Denials and Appeals,* your provider may act as your authorized representative. Signing a provider form is not sufficient to designate the provider as your authorized representative.

The Plan also prohibits assignments of any other rights you may have under ERISA, including, without limitation, the right to request documents under section 104 of ERISA and the ability to:

· enforce rights under the terms of the Plan;

· to clarify rights to future benefits under the terms of the Plan;

· obtain relief for a breach of fiduciary duty;

· enjoin any act or practice which violates ERISA or the terms of the Plan or to obtain other equitable relief to redress such violations or enforce any provisions of ERISA or the Plan; and

· obtain relief based on the Plan Administrator's failure to provide information or other documentation to which a participant or beneficiary may be entitled under ERISA.

If Benefits are paid to a non-Network provider, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan or another plan (including amounts owed as a result of the assignment of other plans' overpayment recovery rights to the Plan) pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

The Claims Administrator will pay Benefits to you unless:

- The provider submits a claim form to UnitedHealthcare that you have signed authorizing the payment of those Benefits directly to that provider; OR

- You make a written request to UnitedHealthcare for the non-Network provider to be paid directly at the time you submit your claim.

The Claims Administrator will only pay Benefits to you or your provider of those Benefits. Benefits will not be paid to any third party, even if you or your provider purports to have assigned Benefits to that third party.

Form of Payment of Benefits

Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that the Claims Administrator in its discretion determines to be adequate. Where Benefits are payable directly to a provider, such adequate consideration includes the forgiveness in whole or in part of amounts the provider owes to other plans for which the Claims Administrator makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

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 Claims
All claims for services must be submitted within 12 months from the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated; however, if you cease to be legally incapacitated, the deadline will be 12 months from the date you cease to be 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

The Claims Procedures apply to (i) any denial, reduction or termination of, or failure to make payment for, a medical benefit (including a prescription drug benefit) under the Plan; and (ii) any rescission of coverage by the Plan (a rescission of coverage would be an adverse benefit determination that can be appealed under the appeal procedures described below).

Representative – You may designate a representative to act on your behalf in pursuing a medical benefit claim or prescription drug benefit claim. You should contact the Claims Administrator to find out how to designate a representative. In the case of an urgent care claim (see below), your provider may act on your behalf as your authorized representative.

Claims Requiring Pre-Approval

If you are required to obtain pre-approval from the Claims Administrator as a prerequisite to obtaining a medical benefit, you or your Physician must file for pre-approval with the Claims Administrator. If you or your Physician contacts the Claims Administrator to obtain pre-approval for a pre-service claim, but fail to follow the procedure for pre-approval, the Claims Administrator will notify you or your Physician of the failure and of the proper procedure for filing for pre-approval. The Claims Administrator will provide this notice as soon as possible, but not later than 5 days after the failure, or, in the case of an urgent care claim (see below) within 24 hours of the failure. The notice by the Claims Administrator may be given orally unless you request a written notice.

Period for Determining Claims

The period during which the Claims Administrator is required to decide a claim depends on the type of claim being made. There are generally three types of claims – a pre-service claim, an urgent care claim and a post–service claim. There is a fourth type of claim – a concurrent care claim – that can occur when you are already undergoing an ongoing course of treatment.

Pre-Service Claim – A pre-service claim is a claim for a medical benefit or prescription drug benefit that requires some form of pre-approval by the Claims Administrator. The Claims Administrator must decide a pre-service claim (other than an urgent care claim) within 15 days. This 15-day period may be extended for up to an additional 15 days if the Claims Administrator determines that the extension is necessary for reasons beyond its control. The Claims Administrator will notify you in writing or electronically if there is an extension. The notice must include an explanation of the reason for the extension, as well as the date by which the Claims Administrator expects to render its decision. If the extension is due to a faulty claim, the notice of extension of time to decide the claim will describe the specific information you must provide to the Claims Administrator. You will be provided at least 45 days from receipt of the notice to provide the necessary information. The period of time for the Claims Administrator to make its decision will be tolled from the date a notice of extension and request for additional information is provided to you until the date on which you provide the requested additional information.

Urgent Care Claim – An urgent care claim is a pre-service claim where application of the normal period for deciding pre-service claims could jeopardize your life, your health or your ability to regain maximum function, or would subject you to severe pain that cannot be adequately managed without the care or treatment that is being claimed. The Claims Administrator is required to decide an urgent care claim within 72 hours. If the claim is incomplete, so that a determination cannot be made of whether the proposed medical procedure is covered or payable under the Plan, the Claims Administrator will notify you or your Physician within 24 hours of receipt of the claim, or sooner if possible, of the information needed to complete the claim. You or your Physician will have 48 hours after receipt of the notice to provide the information. Once the additional information is received by the Claims Administrator, the claim will be decided within 48 hours of the earlier of (i) the receipt of the specified information by the Claims Administrator, or (ii) expiration of the 48-hour period afforded to you to provide the specified information.

Post-Service Claim – A post-service claim is any medical benefit claim or prescription drug benefit claim that is not a pre-service claim. It would include a claim in which the medical procedure has already occurred and you are seeking payment of it or reimbursement for it. A prescription drug benefit claim will almost always be a post-service claim. The Claims Administrator is required to decide a post-service claim within 30 days. This 30-day period may be extended for up to an additional 15 days if the Claims Administrator determines the extension is necessary for reasons beyond its control. The Claims Administrator is required to notify you in writing or electronically if there is an extension. The notice must include an explanation of the reason for the extension, as well as the date by which the Claims Administrator expects to render its decision. If the extension is due to a faulty claim, the notice of extension of time to decide the claim will describe the specific information you must provide to the Claims Administrator. You will be provided at least 45 days from receipt of the notice to provide the necessary information. The period of time for the Claims Administrator to make its decision will be tolled from the date a notice of extension and request for additional information is provided to you until the date on which you provide the requested additional information.

Concurrent Care Claim - In addition, some special rules apply where the Claims Administrator has already approved an ongoing course of treatment over a period of time or number of treatments. First, if the Claims Administrator reduces or terminates coverage for the course of treatment before it otherwise would have ended, that reduction or termination is a benefit denial. The Claims Administrator must notify you in writing or electronically sufficiently in advance of the reduction or termination to allow you to appeal the decision (see "How to Appeal a Denied Claim" below), and to obtain a decision on any appeal. Second, if you request an extension of the course of treatment at least 24 hours before the course of treatment ends and it is an urgent care situation (see "Urgent Care Claim" above), the Claims Administrator must notify you within 24 hours of its decision on the extension request.

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole (an adverse benefit determination), 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.

You will be given written or electronic notice of any adverse benefit determination. The notice will set forth:

- Information sufficient to identify the claim involved, including (i) the date of service; (ii) the health care provider; and (iii) the claim amount (if applicable). Further, the notice will advise you of your right to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- The specific reason or reasons for the denial or partial denial of the benefit claim, including (i) the denial code and its corresponding meaning; and (ii) a description of the Claims Administrator's standard, if any, that was used in denying the claim.
- The specific provisions of the Plan and any other document on which the denial is based. If the decision to deny benefits is based, in whole or in part, on a specific internal

rule, guideline, protocol or similar criteria, either a copy of the document will be provided to you or you will be advised that you may request a copy of the document from the Claims Administrator at no charge. If the decision to deny benefits is based, in whole or in part, on an exclusion or limitation that the medical treatment or drug is Experimental or Investigational, or that the treatment is not medically necessary, either an explanation that applies the appropriate terms to your medical circumstances, and which details the scientific or clinical judgment that led to the decision to deny benefits will be provided to you or you will be advised that you may request such an explanation from the Claims Administrator at no charge.

- A description of any additional material or information necessary for you to complete the claim, and an explanation of why such information or material is necessary.
- Information as to how you can appeal the denial, both internally and through the external appeals process, together with how to initiate an appeal and the applicable time limits. This must also include the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman who can assist you with your appeal.
- A statement regarding your right to bring a civil suit under federal law should you appeal the claim denial and the denial is upheld on appeal.

When an urgent care claim is involved, the notice of denial may be provided orally initially, but will be provided in writing or electronically within three days of the oral notice.

How to Appeal a Denied Claim

If you wish to appeal an adverse benefit determination or a rescission of coverage (coverage that was cancelled or discontinued retroactively), you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination or notice of rescission of coverage. You do not need to submit urgent care appeals in writing.

Urgent Appeals that Require Immediate Action

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

An appeal 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.
- Any documentation or other written information to support your request.

When you appeal a denied claim, you may submit written comments, documents, records and additional justification of why the claim should be allowed. Pursuant to the appeal, you are entitled to receive upon request, free access to and copies of all documents, records and other information relating to the claim. The Claims Administrator shall provide you with the name of each medical or vocational expert whose advice was obtained in connection with the denied claim, regardless of whether the advice was relied upon. The Claims Administrator is also required to provide you with any new or additional evidence considered, relied upon or connected with the claim. The Claims Administrator must provide any additional evidence as soon as possible and sufficiently in advance of the date on which the Claims Administrator must provide its final determination so that you have a reasonable opportunity to respond to the new evidence. If the Claims Administrator is going to rely on any new or additional rationale for denying the claim, the Claims Administrator must provide you with such new or additional rationale as soon as possible and sufficiently in advance of the date on which it must provide its final determination so that you have a reasonable opportunity to respond to the new rationale.

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

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 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.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal that takes into account all comments, documents, records and other claim-related information. No deference will be given to the initial determination. The appeal will be conducted by:

- An appropriate individual(s) who did not make the initial benefit determination, nor is a subordinate of the individual(s) who made the initial determination.
- A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

The Claims Administrator will make a determination on the appeal and communicate its decision to you or your representative within the following timeframes.

Urgent Care Claims - Decisions on review of urgent care appeals will be made and communicated in writing or electronically within 72 hours of receipt of the request for review.

Pre-Service Claims - Decisions on review of pre-service claims will be made and communicated in writing or electronically as soon as reasonable, but not later than 30 days of the receipt of the request for review.

Post-Service Claims - Decisions on review of post-service claims will be made and communicated in writing or electronically as soon as reasonable, but not later than 60 days of the receipt of the request for review.

Once the review is complete, the Claims Administrator will communicate its decision to you or your representative in writing or electronically. If the Claims Administrator upholds the denial, in whole or in part, the notice will contain:

- Information sufficient to identify the claim involved, including (i) the date of service; (ii) the health care provider; and (iii) the claim amount (if applicable). Further, the notice will advise you of your right to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.
- The specific reason or reasons for the adverse determination of all or any part of the claim, including (i) the denial code and its corresponding meaning; and (ii) a description of the Claims Administrator's standard, if any, that was used in denying the claim. The description of the Claims Administrator's standard must include a discussion of the decision.
- The specific provisions of the Plan and any other document on which the adverse determination is based.
- A statement that you may obtain, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits. If an internal rule, guideline, protocol or similar criteria was relied upon in making the adverse determination, the Claims Administrator must either provide a copy to you with the written notice or advise you that it will provide a copy free of charge upon request. If the adverse determination is based on medical necessity, experimental treatment or a similar exclusion, the Claims Administrator must either provide an explanation of the scientific or clinical judgment for the adverse determination with the written notice, or advise you that it will provide it free of charge upon request.
- Information on the external appeals process, including how to initiate an external appeal and the applicable time limits.
- A statement regarding the claimant's right to bring a civil suit under federal law.

This Plan does not have other voluntary alternative dispute resolution options. However, you may contact your local U.S. Department of Labor Office and/or State insurance regulatory agency for assistance.

External Review Program

If you have exhausted the Plan's internal claims procedures and had your claim denied, in whole or in part, on appeal, you may be entitled to an external appeal. In limited circumstances, you may be eligible for an expedited external appeal of an

initial adverse claim decision even though you have not exhausted the Plan's internal claims procedures.

An external appeal is available for (i) a claim that involves medical judgment (including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered treatment; or its determination that a treatment is experimental); (ii) a rescission of coverage; or (iii) any adverse determination by the Plan under section 716 or 717 of ERISA and guidance issued thereunder, including a determination of whether a service or item is subject to either section. The U.S. Department of Labor or other appropriate federal agency may further limit or broaden the scope of external appeals. The Plan will provide an external appeals process in accordance with any such additional guidance.

A request for an external appeal must be filed with the Claims Administrator in accordance with the instructions contained in the notice you receive denying your claim on an internal appeal (the "appeal denial notice"). A request for an external appeal must be filed within four months after the date you receive the appeal denial notice. If there is no corresponding date four months after the date of the appeal denial notice, then the request must be filed by the first day of the fifth month following receipt of the appeal denial notice. For example, if you receive the appeal denial notice on October 30th, because there is no February 30th, the external appeal request must be filed by March 1st. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday.

Within five business days of receiving an external appeals request, the Claims Administrator shall complete a preliminary review to determine if the request is complete and eligible for external appeal. The preliminary review will determine (i) whether you were covered under the Plan at the time the health care item or service was requested or provided; (ii) whether the adverse claim decision relates to your failure to meet the Plan's eligibility requirements; (iii) whether you exhausted the internal appeal process (or was not required to exhaust the internal appeal process); and (iv) whether you have provided all information and forms required to process an external appeal. Within one business day after the Claims Administrator completes its preliminary review, it will issue a written notification to you. If the external appeals request is complete, but you are not eligible for an external appeal, the notice will include the reasons for ineligibility and contact information for the Employee Benefits Security Administration of the U.S. Department of Labor. If the external appeal request is not complete, the notification will describe the information or materials needed to make the request complete and you will be allowed to perfect the external appeal request by the later of (i) the final day of the original four month filing period, or (ii) then end of the 48-hour period following your receipt of the notice.

If your external appeal request is complete and eligible, the Claims Administrator will assign a qualified Independent Review Organization ("IRO") to conduct the external appeal procedure. Within five business days of the assignment of the IRO by the Claims Administrator, the Claims Administrator will provide the IRO with the

documents and any information considered in the denial of the claim, either initially or on internal appeal.

The assigned IRO will timely notify you in writing of the eligibility and acceptance of the request for external review. The notice from the IRO will include a statement that you may submit in writing to the IRO additional information that the IRO must consider when conducting the external review. Such additional information must be submitted within ten business days of your receipt of the notice from the IRO (or such longer period the IRO may provide). If you submit additional information to the IRO, the IRO will send that information to the Claims Administrator, and the Claims Administrator may reconsider its denial of the claim. If the Claims Administrator does not reverse its denial of the claim, the IRO will review all documents and information that it received in a timely manner. To the extent the information or documents are available and the IRO considers them appropriate, the IRO shall also consider the following in reaching a decision: (i) your medical records; (ii) the attending health care professional's recommendation; (iii) reports from the appropriate health care professionals and other documents submitted by the Plan, you or your treating provider; (iv) the terms of the Plan (to ensure the IRO's decision is not contrary to the terms of the Plan); (v) appropriate practice guidelines (including applicable evidence-based standards); (vi) any appropriate clinical review criteria; and (vii) the opinion of the IRO's clinical reviewer.

The IRO shall provide a written notice to both you and the Claims Administrator of its final determination on the external appeal within 45 days of its receipt of the request for external appeal. The written notice shall contain:

- A general description of the reason for the request for external appeal, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment of the external appeal and the date the IRO made its decision;
- References to the evidence or documentation considered by the IRO in reaching its decision, including specific coverage provisions and evidence based standards;
- A discussion of the principal reason or reasons for the decision, including the rationale for the decision and any evidence-based standards that were relied upon in making the decision;
- A statement that the decision is binding except to the extent that other remedies may be available under applicable state or Federal law to either you or the Plan;
- A statement that judicial review may be available to you; and
- Current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the IRO reverses the adverse claim decision, the Plan shall immediately provide coverage or payment for the claim.

Expedited External Appeal

In certain circumstances, you may be entitled to an expedited external appeal. In an expedited external appeal, the Claims Administrator will complete a preliminary review to determine if your claim is eligible for an external appeal and will immediately after completion of the preliminary review, issue a written notification to you of the eligibility of the claim for an external appeal. If your request is complete, but the claim is not eligible for external appeal, the notice will include the reasons for ineligibility. If the request is incomplete, the notice will describe the information or materials needed to make the request complete and you will be given an opportunity to complete the request.

Upon a determination that the request is eligible for an expedited external appeal, the Claims Administrator will assign an IRO to review the expedited external appeal. The Claims Administrator will transmit to the IRO all necessary documents and information considered in denying the claim. The transmission shall be done electronically, by telephone or facsimile, or by any other available expeditious method. The IRO will provide notice of the decision of the external appeal in the same manner as for a normal external appeal except that (i) such notice shall be provided as expeditiously as your medical conditions or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external appeal; and (ii) the notice may be provided orally, telephonically, electronically or by other means, so long as within 48 hours of when the notice is provided, the IRO provides written confirmation of its decision to both you and the Plan.

A claim shall be entitled to an expedited external appeal if the claim is otherwise eligible for an external appeal and (i) the claim involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited external appeal; (ii) the claim was denied at the internal appeal level and you have a medical condition where the timeframe for completion of a normal external appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or (iii) the claim was denied at the internal appeal level and the claim involves an admission, availability of care, continued stay, or health care item or service for which you received emergency services and you haves not been discharged from the medical facility.

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.

Limitation of Action

You cannot bring any legal action against the Plan or the Claims Administrator for claims for Benefits or equitable relief unless you first complete all the steps of the claims and appeal

process described in this section. You must wait to file a lawsuit until at least 90 days after a request for reimbursement has been properly submitted as described in this section and all the required reviews of your claim have been completed. After completing the claims and appeal process, if you want to bring a legal action against the Plan or the Claims Administrator you must do so within three years of the date of the final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides coverage to you.

When Does Coordination of Benefits Apply?

This *Coordination of Benefits (COB)* provision 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.
- 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. How much this Plan will reimburse you, if anything, will also depend in part on the Allowable Expense. The term, "Allowable Expense," is further explained below.

What Are the Rules for Determining the Order of Benefit Payments?

Order of Benefit Determination Rules

The order of benefit determination rules determine whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one plan. When this Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that benefits provided by all the plans does not exceed 100% of the total Allowable Expense.

The order of benefit determination rules below govern the order in which each plan will pay a claim for benefits.

- **Primary Plan.** The plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms

without regard to the possibility that another plan may cover some expenses.

- **Secondary Plan.** The plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total Allowable Expense. Allowable Expense is defined below.

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

A. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.

B. When you have coverage under two or more medical plans and one of the plans has no COB provisions, that plan without COB provisions will pay benefits first.

C. If neither A nor B applies, each plan determines its order of benefits using the first of the following rules that apply:

1. **Non-Dependent or Dependent**. The plan that covers the person other than as a dependent, for example as an employee, former employee under COBRA, policyholder, subscriber or retiree is the Primary Plan and the plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, policyholder, subscriber or retiree is the Secondary Plan and the other plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      (2) If both parents have the same birthday, the plan that has provided coverage to a parent the longest is the Primary Plan.
   b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but a spouse of that parent does, that spouse's plan is the Primary Plan. This provision shall not apply with

respect to any period during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

(3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

(4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a) The plan covering the custodial parent.
b) The plan covering a spouse of the custodial parent.
c) The plan covering the non-custodial parent.
d) The plan covering the non-custodial parent's spouse.

For purpose of this section, the custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

d) (i) For a dependent child who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the rule in paragraph 5 below applies.
(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

3. **Active Employee or Retired or Laid-off Employee.** The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1. can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the plan providing COBRA or state or other federal continuation coverage is the Secondary Plan. If the other plan does not have this rule, and as a result, the plans do not

agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled C.1 can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The plan that covered the person the longer period of time is the Primary Plan and the plan that covered the person the shorter period of time is the Secondary Plan.

6. If none of the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the Primary Plan.

How Are Benefits Paid When This Plan is Secondary?

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

- The Plan determines the amount it would have paid based on the Allowable Expense.
- If this Plan would have paid the same amount or less than the Primary Plan paid, this Plan pays no Benefits.
- If this Plan would have paid more than the Primary Plan paid, the Plan will pay the difference.

You will be responsible for any applicable Copayment, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the Allowable Expense.

How is the Allowable Expense Determined when this Plan is Secondary?

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 the provider is a network provider for the Primary 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 the Primary Plan and a non-Network provider for this Plan, the Allowable Expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled "Determining the Allowable Expense When this Plan is Secondary to Medicare".

What is Different When You Qualify for Medicare?

Determining Which Plan is Primary When You Qualify for Medicare

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:

- A covered Employee, his/her covered spouse, and his/her covered Dependents, provided the covered Employee is covered by virtue of his/her active current employment status.
- If you (or a covered spouse or Dependent) are eligible for Medicare on the basis of end-stage renal disease, this Plan pays primary for the first 30 months after you (or the spouse or Dependent) are enrolled in (or eligible to enroll in) Medicare. Thereafter, this Plan pays secondary to Medicare regardless of whether or not you (or the spouse or Dependent) enroll in Medicare. Please contact the Benefits Operations & Planning Section of Erie Insurance for more information.

Determining the Allowable Expense When this Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Allowable Expense will be determined as follows.

If you have enrolled in Medicare and the provider accepts reimbursement directly from Medicare (a "Medicare participating provider"), the Medicare approved amount is the Allowable Expense. The Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such providers a percentage of its approved amount – often 80%.

If you have enrolled in Medicare and the provider accepts Medicare but does not accept assignment of your Medicare benefits (a "non-participating provider"), the Medicare limiting charge (the most a non-participating provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the Allowable Expense.

If you have enrolled in Medicare and the provider does not accept Medicare at all and has signed an agreement to be excluded from the Medicare program (an "Opt-Out provider"), the Medicare approved amount is the Allowable Expense. In addition, it will be treated as if Medicare reimbursed its percentage of its approved amount.

If you are eligible for Medicare but you have **not** enrolled in Medicare, you will be treated as if you timely enrolled in Medicare and had obtained services from a Medicare participating provider and the Medicare approved amount will be the Allowable Expense. In addition, it will be treated as if Medicare reimbursed its percentage of its approved amount.

Medicare payments, combined with Plan Benefits, will not exceed 100% of the Allowable Expense.

When calculating the Plan's Benefits in these situations, and when Medicare does not issue an EOMB, for administrative convenience the Claims Administrator may use the provider's billed charges for covered services as the Allowable Expense.

Medicare Crossover Program

United Healthcare offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your

Dependent will also have this automated Crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and DME 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.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to 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 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. The Claims Administrator may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

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

Does This Plan Have the Right of Recovery?

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 the Plan 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 Plan may recover the amount in any manner allowable by applicable law. The Plan 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, the Claims Administrator reserves the right to recover the excess amount on behalf of the Plan 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 any of the following occur:

- 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 (or on behalf of) 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.
- 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 refund is due from the Covered Person and the Covered Person 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, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than you, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which the Claims Administrator processes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will either:

- 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.

If a Covered Person obtains services at a non-Network provider that has patients that are covered under other health plans for which UnitedHealthcare is the claims administrator or insurance carrier, special rules may apply. On occasion, those other health plans may pay the non-Network provider more than what those other health plans were designed to pay. In exchange for this Plan benefiting from the overpayment recovery process described in (ii) in the preceding paragraph, this Plan may reduce its payment to the non-Network provider below the amount the Plan would otherwise pay towards the Eligible Expenses amount. The amount of the reduction will correspond to the amount of the overpayments made by one or more other plans to that non-Network provider. The difference between the Plan's share of the Eligible Expenses amount and the actual amount paid to the non-Network provider by the Plan will be paid to the other plans so that they can recover their overpayments. If the

non-Network provider attempts to bill you for those amounts, you should contact UnitedHealthcare.

Any amounts paid by this Plan to other health plans shall be from Erie Insurance's general assets and shall not be attributable to any contributions made by Covered Persons or on behalf of Covered Persons for the cost of coverage. Only if the total amount of the overpayment recovery payments made to other plans exceeds the difference between total Benefit payments made by the Plan in the year and the amount of contributions made by Covered Persons or on behalf of Covered Persons for the cost of coverage in the year will such overpayment recovery payments be considered attributable to contributions made by or on behalf of Covered Persons.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. References to "you" or "your" in this Subrogation and Reimbursement section shall include you, your estate and your heirs and beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid Benefits on your behalf for a Sickness or Injury for which any third party is allegedly 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 any third party is considered 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 it is alleged that any third party caused or is responsible for 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 receive for that Sickness or Injury. The right of reimbursement applies to any Benefits received at any time until the rights are extinguished, resolved or waived in writing.

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.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to a Sickness or Injury you allege or could have alleged were the responsibility of any third party.

- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

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.
  - 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 the right to 100 percent of the Benefits paid or to be paid by the Plan in connection with a Sickness or Injury for which a third party may be responsible. The Plan has a first priority right to receive payment on any claim against any 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 and regardless of whether under the terms of the judgment or settlement, there is a finding or admission of fault of or by the third party. 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 and/or your representative shall hold those funds in trust, either in a separate bank account in your name or in your representative's trust account.
- You will hold any full or partial settlements, judgments, or other recoveries paid or payable to you or your representative in a constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid in full. In the event that you die as a result of your injuries and a wrongful death or survivor claim is asserted against a third party, the Plan's subrogation and reimbursement rights shall still apply.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- By participating in and accepting Benefits from the Plan, you agree to assign to the Plan any Benefits, claims or rights of recovery you have under any automobile policy - including no-fault Benefits, PIP Benefits and/or medical payment Benefits - other coverage or against any third party, to the full extent of the Benefits the Plan has paid for the Sickness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting Benefits, you acknowledge and recognize the Plan's right to assert, pursue and recover on any such claim, whether or not you choose to pursue the claim, and you agree to this assignment voluntarily.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical Benefits you receive for the Sickness or Injury out of any settlement, judgment or other recovery from any third party considered responsible and filing suit in your name or your estate's name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund Benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries. In the case of your death the Plan's right of reimbursement and right of subrogation shall apply if a claim can be brought on behalf of you or your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, 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 any 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 also 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 Annual Deductible.
- Advanced during the time period of meeting the applicable Out-of-Pocket Limit 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.

- 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 Annual Deductible and/or meeting the applicable Out-of-Pocket Limit 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.
- 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.
- 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.

When your coverage ends, the Plan 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.

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

- The date your employment with the Employer ends, unless specific coverage is available for retired or pensioned persons and you are eligible for and remain enrolled in such coverage.
- The date the Plan ends.
- The date you stop making the required contributions.
- In the event you have coverage as an Eligible Retiree, the date your coverage period (as described below) ends.
- The date you are no longer eligible.
- The date UnitedHealthcare receives written notice from Erie Insurance to end your coverage, or the date requested in the notice, if later.

Coverage for an eligible Dependent will end on the earliest of:

- The date your coverage ends.
- The date you stop making the required contributions for your Dependent's coverage.
- The date that you change your coverage option to an option that no longer provides coverage for your Dependent. For example, if you change your coverage option from family coverage to employee plus children coverage, your covered Spouse will lose coverage as of the effective date of the change in coverage.
- The date UnitedHealthcare receives written notice from Erie Insurance to end your Dependent's coverage, or the date requested in the notice, if later.
- The date your Dependent no longer qualifies as a Dependent under this Plan. If a Dependent child no longer qualifies as a Dependent solely due to the attainment of age 26, coverage will remain in effect until the last day of the month in which the Dependent child attained age 26.

Other Events Ending Your Coverage

The Plan will provide at least thirty days 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, knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the 30-day notice period. The notice will contain information on how to pursue your appeal.

Note: If UnitedHealthcare and Erie Insurance find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan has the right to demand that you pay back all Benefits the Plan has paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage Period for an Eligible Retiree

The period of coverage for an Eligible Retiree is measured from the Eligible Retiree's date of retirement and will be as follows, but will in no event exceed a total of sixty months.

Age and Service	Coverage Period
Attained age 60 by and had 15 years of credited service by July 1, 2006	60 months
Attained age 60 by and had 15 years of credited service by July 1, 2007	48 months
Attained age 60 by and had 15 years of credited service by July 1, 2008	36 months
Attained age 60 by and had 15 years of credited service by July 1, 2009	24 months
Attained age 60 by and had 15 years of credited service by July 1, 2010	12 months

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches age 26 when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- You notify the Claims Administrator at least 31 days before the end of the month in which the child reaches age 26.
- 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 the Plan 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.
- You provide proof, upon the Plan's request, that the child continues to meet these conditions.

The proof might include medical examinations at the Plan'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. UnitedHealthcare will determine whether the child remains disabled, while Erie Insurance will determine whether the other requirements for continuing coverage are satisfied.

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. If the Dependent ceases to be covered under the Plan for any reason, your disabled Dependent will no longer be eligible as a Dependent and you may not re-enroll him/her in the Plan.

Continuation Coverage

The Plan provides continuation of coverage rights as described below to extend temporary coverage to covered Employees and Dependents in certain circumstances when they would otherwise lose their coverage under the Plan. These continuation of coverage rights are intended to comply with the applicable provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

In the event that an Employee or Dependent is a "Qualified Beneficiary" and loses coverage under the Plan as a result of a "Qualifying Event," the Employee or Dependent will have the right to elect continuation coverage under the Plan.

A Qualified Beneficiary is:

1. A covered Employee, but only if the Qualifying Event is the Employee's termination of employment (other than for gross misconduct) or the reduction of the Employee's hours so that the Employee is no longer a full-time Employee.

2. A Spouse of a covered Employee provided the Spouse has coverage in effect at the time of the Qualifying Event.

3. Any other Dependent of a covered Employee provided the Dependent has coverage in effect at the time of the Qualifying Event.

Under the Plan, a covered Employee who qualifies as an Eligible Retiree is a Qualified Beneficiary at the time of his or her retirement and may elect continuation coverage at that time in lieu of continuing his or her coverage under the Plan as an Eligible Retiree. In the event that a covered Employee elects to continue coverage as an Eligible Retiree under the Plan and coverage terminates within the applicable maximum continuation coverage period, the Employee may elect continuation coverage for up to the remainder of the applicable maximum continuation coverage period (measured from the date of the Employee's retirement).

Note: A child born to, or placed for adoption with, the covered Employee or the Employee's Spouse or former Spouse while such person is on continuation coverage under the Plan is a Qualified Beneficiary, provided the child is enrolled for coverage within 31 days following the date of birth or placement for adoption.

The following are Qualifying Events:

1. **Termination of Employment/Reduction in Hours**—One Qualifying Event is the termination of a covered Employee's employment (other than for gross misconduct) or the reduction in the covered Employee's hours so that the Employee is no longer a full-time Employee. If this Qualifying Event occurs, the Employee may elect to continue the coverage that he or she had in effect under the Plan for up to 18 months following the date on which the Qualifying Event occurred. If the Employee's Spouse or Dependents have coverage, the Spouse or Dependents will have the right to purchase continuation coverage individually. However, if the form of coverage elected by the Employee provides coverage for the Spouse or Dependents, the Spouse or Dependents need not elect to continue coverage individually. The 18-month period may be extended for up to an additional 11 months in the event that an Employee, a Spouse or Dependent receiving continuation coverage is determined to be disabled for purposes of Social Security at any time during the first 60 days of continuation coverage. However, in order for the Employee or any Dependent to obtain the additional 11 months of continuation coverage the Employee or Dependent must notify the COBRA Administrator for the Plan, UnitedHealthcare in writing within 60 days of when Social Security makes its determination, but in no case later than the last day of the 18 month continuation coverage period. A copy of the Social Security Administration's disability award notice must also be provided to the COBRA Administrator, UnitedHealthcare.
2. **Death of Employee**—If a covered Employee has a form of coverage that provides coverage for his or her Spouse or Dependents at the time of his or her death, any covered Spouse or covered Dependents will have the right to purchase up to 36 months of continuation coverage from the date of the Employee's death. Coverage will automatically be provided to any covered Spouse or covered Dependents for the 31-day period following the date of the Employee's death.
3. **Divorce**—If a covered Employee has a form of coverage that provides coverage for his or her Spouse and the Employee becomes divorced from his or her Spouse the Spouse and any other Dependent that will lose coverage as a result of the divorce will have the right to purchase up to 36 months of continuation coverage from the date of the divorce.
4. **Entitlement to Medicare**—If a covered Employee has a form of coverage that provides coverage to his or her Spouse or Dependents and the Employee becomes entitled to Medicare and elects Medicare as his or her primary coverage, the Plan is prohibited from providing coverage to the Employee. The Employee's Spouse and Dependents who lose coverage as a result of the Employee's election will have the right to purchase up to 36 months of continuation coverage from the date on which the Employee's election is effective.
5. **Child Ceases to be Dependent**—If a child is covered as a Dependent and the child ceases to qualify as a Dependent of the covered Employee, the child can purchase up to 36 months of continuation coverage from the date the child ceases to qualify as a Dependent.
6. **Multiple Qualifying Events**—If an Employee lost coverage because of termination

of employment or reduction in hours and the Employee's Spouse or Dependents are receiving continuation coverage and then one of the events listed in paragraphs 2 through 5 occurs, the Spouse or Dependents may elect to continue coverage for an additional period of time not to exceed the date that is 36 months from the date of the Employee's termination of employment or reduction in hours.

With respect to Eligible Retirees, a Qualifying Event also occurs with respect to the Plan if Erie Insurance commences certain bankruptcy proceedings.

Each individual who is eligible to elect continuation coverage must make a written election for continuation coverage no later than the day that is 60 days after the later of the date coverage would otherwise end or the date that the COBRA Administrator, UnitedHealthcare, provides written notice of the right to purchase continuation coverage. The written election must either be hand-delivered to the COBRA Administrator, UnitedHealthcare, or postmarked on or before the 60th day or the individual will not be permitted to elect continuation coverage.

A covered Employee or the Employee's Spouse or Dependents must notify the Benefits Operations & Planning Section of Erie Insurance as soon as possible (but not later than 60 days) after the Employee and his or her covered Spouse are divorced, or a covered Dependent child ceases to qualify as a Dependent. The notice must be provided in writing.

A part-time Employee or former Employee who is on continuation coverage must notify the COBRA Administrator, UnitedHealthcare, as soon as possible (but not later than 60 days after the part-time Employee or former Employee and his or her covered Spouse are divorced, a covered Dependent child ceases to qualify as a Dependent or the part-time Employee or former Employee or covered Spouse or Dependent receives a Social Security disability determination. The notice must be provided in writing. In the case of a Social Security Administration determination of disability, a copy of the Social Security Administration disability award notice must be provided to the COBRA Administrator, UnitedHealthcare. Further, the COBRA Administrator or Plan Administrator may request that documentation or additional information be provided in the case of one of these Qualifying Events (for example, if the Qualifying Event is divorce, a copy of the divorce decree may be requested). If notice is not provided within 60 days after one of these events occurs or documentation or additional information requested is not timely provided, continuation coverage will not be available (in the case of a disabled individual, extended continuation coverage will not be available).

If the Qualifying Event is termination of employment (other than for gross misconduct) or reduction in hours of employment, the COBRA Administrator will notify the Employee and any covered Dependents of the right to purchase continuation coverage. Notice will be provided within 44 days of the date of the Employee's termination or reduction in hours.

If the Qualifying Event is the Employee's death or entitlement to Medicare (and the

election of Medicare as the Employee's primary coverage) and the Employee's Spouse and/or Dependents have coverage, the COBRA Administrator will notify the Employee's Spouse and/or Dependents of their right to purchase continuation coverage. Notice will be provided within 44 days of the Employee's death or the effective date of the Employee's Medicare coverage.

If the Qualifying Event is divorce or loss of Dependent child status and the Employee or Dependent has timely provided proper notification and provided any additional information or documentation requested, the COBRA Administrator will provide a written notice of the right to purchase continuation coverage to the affected Dependent(s) within 14 days of when the notice is provided.

The monthly amount you will pay for continuation coverage under the Plan will be no more than 102 percent of the applicable premium (as determined in accordance with COBRA and regulations issued pursuant to COBRA) for coverage under the Plan, and 150 percent of the applicable premium for coverage for the 19th through 29th months of coverage for disabled individuals who are eligible for 11 additional months of continuation coverage. Payment of the monthly amount is due by the first day of each month of continuation coverage, provided that the initial payment of the monthly amount(s) must be made within 45 days after the election of continuation coverage.

Continuation coverage under the Plan will end as of the date any of the following occur:

- The required payment is not paid on a timely basis. Except for the initial payment (which is due within 45 days of when the election is made), a monthly payment will be treated as timely made if it is made within 30 days of its due date (the grace period).
- The maximum (18-month, 29-month or 36-month) continuation coverage period ends.
- Erie Insurance terminates the Plan.
- The date that the individual becomes covered under another group health plan that does not contain any exclusion or limitation with respect to a pre-existing condition of the person who becomes covered or the date on which the exclusion period ends under the plan. Continuation coverage only ends for the person who becomes covered by the other group health plan.
- The date that the individual becomes enrolled in Medicare. Continuation coverage only ends for the person who becomes enrolled in Medicare.
- If extended coverage is being provided due to a Social Security disability determination, continuation coverage will end at the beginning of the month that begins after 30 days have passed from a final determination that the individual is no longer disabled for purposes of Social Security.

For more information about your continuation coverage rights contact the Benefits Operations & Planning Section of Erie Insurance.

USERRA Continuation Coverage. A covered Employee who is absent from work to serve in the military service may elect to continue coverage under the Plan as mandated by the Uniformed Services Employment and Reemployment Rights Act ("USERRA") under certain circumstances. These rights only apply to an Employee and his or her Dependents that have coverage under the Plan before the military service begins. These rights are in addition to any other rights the Employee and dependents may have for continuation coverage. For more information about your rights under USERRA contact the Benefits Operations & Planning Section of Erie Insurance.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Qualified Medical Child Support Orders.
- Your relationship with UnitedHealthcare and Erie Insurance.
- Relationships with providers.
- Interpretation of the Plan.
- Information and records.
- Incentives to you.
- Amendment or termination of the Plan.
- 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 Erie Insurance

In order to make choices about your health care coverage and treatment, Erie Insurance believes that it is important for you to understand UnitedHealthcare's role with respect to the Plan and how it may affect you. UnitedHealthcare helps administer the Plan. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- UnitedHealthcare makes 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).
- 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.

- UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. You:

- Are responsible for choosing your own provider.
- Are responsible for paying, directly to your provider, any amount identified as your responsibility, including Copayments, Coinsurance, any Deductible and any amount that exceeds Eligible Expenses.
- Are responsible for paying, directly to your provider, the cost of any health service that is not a 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).
- Must decide with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

Interpretation of the Plan

- The Plan Administrator and UnitedHealthcare each have the discretion to interpret the terms, conditions, limitations and exclusions of the Plan, including any amendments to the Plan, as well as this SPD and any modifications to this SPD.
- As Claims Administrator, UnitedHealthcare is solely responsible for determining whether a covered individual is entitled to Benefits under the Plan. As Claims Administrator, UnitedHealthcare has the discretion to make factual determinations related to the Plan and its Benefits.

The Plan Administrator and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan. The identity of the service providers and the nature of their services may be changed from time to time in Plan Sponsor's and the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

Information and Records

Your individually identifiable health information may be used 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. UnitedHealthcare may request additional information from you to decide any claim for Benefits. Your individually identifiable health information will be kept confidential as required by applicable law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish UnitedHealthcare with information or copies of

records relating to the services provided to you, including provider billing and provider payment records, in order to perform its function as Claims Administrator. UnitedHealthcare has the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents. Such information and records will be considered confidential.

The Plan 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 required under applicable law or regulation.

For complete listings of your medical records or billing statements you should 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 the Plan, you may be charged reasonable fees to cover costs for completing the forms or providing the records, as permitted by applicable law.

In some cases, other persons or entities will be designated 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 You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs, surveys, discount programs, administrative programs, and/or programs to seek care in a more cost effective setting and/or from Designated Providers In some instances, these programs may be offered in combination with a non-UnitedHealthcare entity. The decision about whether or not to participate is yours alone but Erie Insurance 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 your ID card if you have any questions. Additional information may be found in Section 7, *Clinical Programs and Resources*.

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.

Amendment or Termination of the Plan

Although Erie Insurance 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. Any amendment or modification of the Plan shall be done by resolution of the Board of Directors of Erie Indemnity Company, and the amendment or modification shall be effective as of the date specified in the enabling resolution. Certain amendments to the Plan may be made by the Employee Benefits Administration Committee of Erie Insurance, which has been delegated that authority by the Board of Directors of Erie Indemnity Company.

Any plan termination shall be done by resolution of the Board of Directors of Erie Indemnity Company, and the plan termination shall be effective as of the date specified in the enabling resolution. A copy of the resolution shall be provided to the Plan Administrator of the Plan and, to the extent necessary or appropriate, to any outside service provider of the Plan. The Plan Administrator of the Plan shall notify plan participants and beneficiaries of the plan termination in accordance with applicable law and regulations.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits and forms part of the Erie Indemnity Company Health Protection Plan. If there is a conflict between this SPD and any benefit summaries (other than summaries of material modifications to the SPD) provided to you, this SPD will control. A copy of the full 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.

Medicare Eligibility

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if the Plan is the secondary payer as described in Section 10, *Coordination of Benefits*, the Plan will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare Advantage (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is the secondary payer, the Plan will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare Advantage plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow those rules, and you will incur a larger out-of-pocket cost.

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.

Air Ambulance – medical transport by rotary wing air ambulance or fixed wing air ambulance helicopter or airplane as such term is used in section 717 of ERISA and regulations issued thereunder.

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.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

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

Ancillary Services – items and services provided by Specified Non-Network Providers at a Specified Network Facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether or not provided by a Physician or a non-Physician practitioner;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such item or service is specifically excluded from the definition of Ancillary Services as determined by the Secretary;
- Provided by such other specialty practitioners as determined by the Secretary; and
- Provided by a non-Network provider if there is no other Network provider who can furnish such item or service at the Specified Network Facility.

Annual Deductible (or Deductible) - the amount you must pay for certain Covered Health Services in a calendar year before the Plan will begin paying certain Benefits in that calendar year. The applicable Deductible is shown in the tables 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.

Bariatric Resource Services (BRS) - a program administered by UnitedHealthcare or its affiliates made available to you under the Plan. The BRS program provides:

- Specialized clinical consulting services to Covered Persons to educate on obesity treatment options.
- Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any amendments to the Plan.

BMI - see Body Mass Index (BMI).

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

Cancer Resource Services (CRS) - a program administered by UnitedHealthcare or its affiliates made available to you under the Plan. The CRS program provides:

- Specialized consulting services, on a limited basis, to Covered Persons with cancer.
- Access to cancer centers with expertise in treating the most rare or complex cancers.
- Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Centers of Excellence - a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to render Covered Health Services for the treatment of specified diseases or conditions. A Centers of Excellence may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Centers of Excellence.

CHD - see Congenital Heart Disease (CHD).

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 charge, stated as a percentage of Eligible Expenses or the Recognized Amount when applicable, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Company - Erie Indemnity Company.

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

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- Be passed from a parent to a child (inherited).
- Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
- Have no known cause.

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

Copayment (or Copay) – the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works* and Section 15, *Outpatient Prescription Drugs*.

Please note that for Covered Health Services for which a Copayment applies, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

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

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which the Claims Administrator determines to be:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary (unless the SPD specifically provides that the health service need not be Medically Necessary).
- Described as a Covered Health Service in this SPD under Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*.

- Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*.
- Not otherwise excluded in this SPD under Section 8, *Exclusions and Limitations*.

Covered Person - either an enrolled Employee (or former Employee) or an enrolled Dependent. A person who is covered under the continuation coverage provisions of Section 12, *When Coverage Ends,* is also a Covered Person. This term applies only while the person is 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 are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that 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.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Definitive Drug Test – a test to identify specific medications, illicit substances and metabolites and that is qualitative or quantitative in order to identify possible use or non-use of a drug.

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 an Employee or Eligible Retiree. No one can be enrolled as a Dependent of more than one Employee or Eligible Retiree.

Designated Network Benefits – for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for the Covered Health Services provided by a Physician or other provider that has been identified as a Designated Provider. Refer to Section 5, *Plan Highlights*, to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Dispensing Entity - a pharmacy, provider, or facility that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies, providers, or facilities are Designated Dispensing Entities.

Designated Provider - a provider and/or facility that:

- Has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrator's behalf, to provide Covered Health Services for the treatment of specific diseases or conditions; or
- The Claims Administrator has identified through the Claims Administrator's designation programs as a Designated Provider. Such designation may apply to specific treatments, conditions and/or procedures.

A Designated Provider may or may not be located within your geographic area. Not all Network Hospitals or Network Physicians are Designated Providers.

You can find out if your provider is a Designated Provider by contacting the Claims Administrator at **www.myuhc.com** or the telephone number on your ID card.

DME - see Durable Medical Equipment (DME).

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:

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

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare or as required by law as detailed in Section 3, *How the Plan Works*.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services - with respect to an Emergency, either I or II below:

- I. A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd* or as would be required under such section if such section applied to an Independent Freestanding Emergency Department*)* that is within the capability of the emergency department of a Hospital, or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency.
- II. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital or an Independent Freestanding Emergency Department, as applicable, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3))*, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further exam or treatment is provided). For the purpose of this definition, "to stabilize" has the meaning as given such term in section *1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).*
- Emergency Health Services also includes items and services otherwise covered under the Plan when provided by a non-Network provider or facility (regardless of the department of the Hospital in which the items are services are provided) after the patient is stabilized and as part of outpatient observation, or as a part of an Inpatient Stay or outpatient stay that is connected to the original Emergency unless the following conditions are met:
    a. The attending Emergency Physician or treating provider determines the patient is able to travel using nonmedical transportation or non-Emergency medical transportation to an available Network provider or facility located within a reasonable distance taking into consideration the patient's medical condition.
    b. The provider furnishing the additional items and services satisfies notice and consent criteria in accordance with applicable law.
    c. The patient is in such a condition, as determined by guidelines issued by the Secretary, to receive information as stated in b) above and to provide informed consent in accordance with applicable law.
    d. The provider or facility satisfies any additional requirements or prohibitions as may be imposed by state law.
    e. Any other conditions as specified by the Secretary.

Unforeseen urgent medical needs that arise at the time the service is provided will be treated as Emergency Health Services regardless of whether notice and consent criteria has been satisfied.

Employee – an individual who has the status of an employee with respect to the Employer under common law. An individual is not an Employee if (i) the individual is a "leased employee" under the Federal Internal Revenue Code; (ii) the individual is on another company's payroll; or (iii) the individual is treated as an independent contractor by the Employer.

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

Employer – The Company and any affiliate of the Company that has adopted the Plan for the benefit of its employees.

EOB - see Explanation of Benefits (EOB).

ERISA - see Employee Retirement Income Security Act of 1974 (ERISA).

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 makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not as appropriate for the proposed use in any of the following:

▪ *AHFS Drug Information (AHFS DI)* under therapeutic uses section;

▪ *Elsevier Gold Standard's Clinical Pharmacology* under the indications section;

▪ *DRUGDEX System by Micromedex* under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb*;* or

▪ *National Comprehensive Cancer Network (NCCN)* drugs and biologics compendium category of evidence 1, 2A, or 2B.

- 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.
- Only obtainable, with regard to outcomes for the given indication, within research settings.

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 may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such

consideration, the Claims Administrator 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.
- The reason(s) why a service or supply was not covered by the Plan.

Fertility Solutions (FS) – a program administered by UnitedHealthcare or its affiliates made available to you under the Plan. The Fertility Solutions program provides:

- Specialized clinical consulting services to Participants and enrolled Dependents to educate on infertility treatment options.
- Access to specialized Network facilities and Physicians for infertility services.
- **Gender Dysphoria** - A disorder characterized by the diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*

Gene Therapy - therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Genetic Counseling - counseling by a qualified clinician that includes:

- Identifying your potential risks for suspected genetic disorders;
- An individualized discussion about the benefits, risks and limitations of Genetic Testing to help you make informed decisions about Genetic Testing; and
- Interpretation of the Genetic Testing results in order to guide health decisions.

Certified genetic counselors, medical geneticists and physicians with a professional society's certification that they have completed advanced training in genetics are considered qualified clinicians when Covered Health Services for Genetic Testing require Genetic Counseling.

Genetic Testing – exam of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder, or provide information to guide the selection of treatment of certain diseases, including cancer.

Gestational Carrier - a Gestational Carrier is a female who becomes pregnant by having a fertilized egg (embryo) implanted in her uterus for the purpose of carrying the fetus to term for another person. The carrier does not provide the egg and is therefore not biologically (genetically) related to the child.

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-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- Has 24 hour nursing services.

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

Independent Freestanding Emergency Department – a health care facility that:

- Is geographically separate and distinct and licensed separately from a Hospital under applicable state law; and
- Provides Emergency Health Services that are described in paragraph I or II of the definition of Emergency Health Services.

Infertility - A disease (an interruption, cessation, or disorder of body functions, systems, or organs) of the reproductive tract which prevents the conception of a child or the ability to carry a pregnancy to delivery.

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 Behavioral Therapy (IBT) – outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples

include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI).*

Intensive Outpatient Treatment - a structured outpatient treatment program.

- For Mental Health Services, the program may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.
- For Substance-Related and Addictive Disorders Services, the program provides nine to nineteen hours per week of structured programming for adults and six to nineteen hours for adolescents, consisting primarily of counseling and education about addiction related and mental health problems.

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

- Fewer than seven days each week.
- 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.

Manipulative Treatment - the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid - a federal program administered and operated 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.

Medically Necessary - health care services, supplies or drugs that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services, supplies or drugs must be:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, Mental Illness, substance-related and addictive disorder, disease or symptoms.

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on **www.UHCprovider.com**.

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

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by UnitedHealthcare that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Health Services - services for the diagnosis and treatment of those mental health or psychiatric categories that are listed in the current edition of the International Classification of Diseases section on Mental, Behavioral and Neurodevelopmental Disorders or the Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental, Behavioral and Neurodevelopmental Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Mental Illness – those mental health or psychiatric diagnostic categories listed in the current edition of the International Classification of Diseases section on Mental, Behavioral and Neurodevelopmental Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental, Behavioral and Neurodevelopmental Disorders or Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment for the condition is a Covered Health Service.

Network (for Health 1, Health 2 and CDHP Options) - 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 UnitedHealthcare 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. UnitedHealthcare's affiliates are those entities affiliated with UnitedHealthcare through common ownership or control with UnitedHealthcare or with UnitedHealthcare'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.

There is no Network for Medicare Supplemental Health 1 and Medicare Supplemental Health 2.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 3, *How the Plan Works*, for details about how Network Benefits apply.

New Pharmaceutical Product - a Pharmaceutical Product or new dosage form of a previously approved Pharmaceutical Product. It applies to the period of time starting on the date the Pharmaceutical Product or new dosage form is approved by the U.S. Food and Drug Administration (FDA) and ends on the earlier of the following dates.

- The date it is reviewed.
- December 31st of the following calendar year.

Non-Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 3, *How the Plan Works*, for details about how Non-Network Benefits apply.

Non-Network Emergency Facility – A non-Network facility provider that is a "nonparticipating emergency facility" as such term is defined in section 716(a)(3)(F)(i) of ERISA and regulations issued thereunder.

Open Enrollment – an annual period of time, determined by Erie Insurance, during which eligible Employees may enroll themselves and their Dependents under the Plan effective as of the start of the following January 1st. Erie Insurance determines the period of time that is the Open Enrollment period.

Out-of-Pocket Limit - the maximum amount you pay every calendar year in Copayments, Coinsurance and Deductibles. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Limit amounts. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Limits works. For Health 1 and Health 2, see Section 15, *Outpatient Prescription Drugs,* for a description of the separate Out-of-Pocket Limit that applies to prescription drugs.

Partial Hospitalization/Day Treatment/High Intensity Outpatient - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Personal Health Support - programs provided by the Claims Administrator 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.

Personal Health Support Nurse - the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Product(s) – *U.S. Food and Drug Administration (FDA)*-approved prescription medications or products administered in connection with a Covered Health Service by a Physician.

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

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist 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 Erie Indemnity Company Health Protection Plan.

Plan Administrator – The committee appointed by the Vice President, Corporate HR of Erie Insurance (or, if there is no person holding that title, the person holding a successor title or acting in a similar capacity with respect to the oversight of the welfare benefit plans maintained by Erie Insurance). This committee is referred to as the Employee Benefits Administration Committee.

Plan Sponsor - Erie Indemnity Company, sometimes referred to as "Erie Insurance".

Pregnancy - includes all of the following: prenatal care, postnatal care, childbirth, and any complications associated with the above.

Preimplantation Genetic Testing (PGT) - A test performed to analyze the DNA from oocytes or embryos for human leukocyte antigen (HLA) typing or for determining genetic abnormalities. These include:

- PGT-M - for monogenic disorder (formerly single-gene PGD).
- PGT-SR - for structural rearrangements (formerly chromosomal PGD).

Presumptive Drug Test – a test to determine the presence or absence of drugs or a drug class in which the results are indicated as a negative or positive result.

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 a home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.
- 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.

Recognized Amount – the amount on which a Copayment, Coinsurance or applicable deductible, is based on for the below Covered Health Services when provided by non-Network providers.

- Non-Network Emergency Health Services.
- Non-Emergency Covered Health Services received at a Specified Network Facility by Specified Non-Network Providers, when such services are either (i) Ancillary Services, or (ii) non-Ancillary Services where either the notice and consent criteria of section *2799B-2(d) of the Public Health Service Act* was not satisfied, or where the notice and consent criteria were satisfied but the Health Services are the result of unforeseen urgent medical needs.

Except for Air Ambulance services provided by a non-Network provider, the Recognized Amount is determined in accordance with section 716(a)(2)(H) of ERISA and regulations issued thereunder.

The Recognized Amount for Air Ambulance services provided by a non-Network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the Air Ambulance service provider.

Note: When your cost sharing for a Covered Health Service is based on the Recognized Amount, the dollar amount you pay may be higher or lower than if cost sharing for these Covered Health Services were determined based upon an Eligible Expense. The cost sharing *percentage* when the Recognized Amount is used should be the same as the cost sharing percentage that would be applied to Eligible Expenses.

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 that 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.

Remote Physiologic Monitoring - the automatic collection and electronic transmission of patient physiologic data that are analyzed and used by a licensed Physician or other qualified health care professional to develop and manage a plan of treatment related to a chronic and/or acute health illness or condition. The plan of treatment will provide milestones for which progress will be tracked by one or more Remote Physiologic Monitoring devices. Remote Physiologic Monitoring must be ordered by a licensed Physician or other qualified health professional who has examined the patient and with whom the patient has an established, documented, and ongoing relationship. Remote Physiologic Monitoring may not be used while the patient is inpatient at a Hospital or other facility. Use of multiple devices must be coordinated by one Physician**.**

Residential Treatment – treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility 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.

- It offers organized treatment services that feature a planned and structured regimen of care in a 24-hour setting and provides at least the following basic services;

    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

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

Secretary – as that term is applied in the *No Surprises Act* of the *Consolidated Appropriations Act (P.L. 116-260).*

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.

Serious and Complex Condition – means one of the following: (a) In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (b)In the case of a chronic illness

or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

Shared Savings Program (does not apply to the Medicare Supplement Health 1 and Medicare Supplement Health 2 Plans) – a program in which UnitedHealthcare may obtain a discount to a non-Network provider's billed charge. This discount is usually based on a schedule previously agreed to by the non-Network provider. When this happens, you may experience lower out-of-pocket expenses. Plan coinsurance and deductibles applicable to non-Network Benefits still apply to the reduced charge. Sometimes Plan provisions or administrative practices supersede the scheduled rate, and a different rate is determined by UnitedHealthcare. This means, when contractually permitted, the Plan may pay the lesser of the Shared Savings Program discount or an amount determined by the Claims Administrator, such as a percentage of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market, an amount determined based on available data resources of competitive fees in that geographic area, a fee schedule established by a third party vendor or a negotiated rate with the provider. In this case the non-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Sickness - physical illness, disease or Pregnancy. The term Sickness 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.
- 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.

Specialty Pharmaceutical Product - Pharmaceutical Products that are generally high cost biotechnology drugs used to treat patients with certain illnesses.

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.

Specified Network Facility – a Network facility that is (i) a hospital, (ii) a hospital outpatient department, (iii) a critical access hospital, (iv) an ambulatory surgical center, or (v) any other facility specified by the Secretary, all as described in section 716(b)(2)(A) of ERISA and regulations issued thereunder.

Specified Non-Network Provider – a Physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable state law and who does not have a contractual relationship with the Plan for furnishing such item or service, as described in section 716(a)(3)(G)(i) of ERISA and regulations issued thereunder.

Spouse - an individual to whom you are legally married.

Substance-Related and Addictive Disorders Services - services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the International Classification of Diseases section on Mental, Behavioral and Neurodevelopmental Disorders or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the edition of the International Classification of Diseases section on Mental, Behavioral and Neurodevelopmental Disorders or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surrogate - a female who becomes pregnant usually by artificial insemination or transfer of a fertilized egg (embryo) for the purpose of carrying the fetus for another person. When the surrogate provides the egg the surrogate is biologically (genetically) related to the child.

Telehealth/Telemedicine - live, interactive audio with visual transmissions of a Physician-patient encounter from one site to another using telecommunications technology. The site may be a CMS defined originating facility or another location such as a Covered Person's home or place of work. Telehealth/Telemedicine does not include virtual care services provided by a Designated Virtual Network Provider.

Terminally Ill – an individual is terminally ill if the individual has a medical prognosis that the individual's life expectancy is 6 months or less.

Therapeutic Donor Insemination (TDI) - Insemination with a donor spermatozoa sample for the purpose of conceiving a child.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision, including those defined in *American Society of Addiction Medicine (ASAM)* criteria, that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment

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

- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide stable and safe housing and the opportunity to learn how to manage activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - health services, including medications and devices, regardless of *U.S. Food and Drug Administration (FDA)* approval, that are not determined to be effective for treatment of the medical condition or not determined 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. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (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) the Claims Administrator may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Care Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator must first establish that there is sufficient evidence to conclude that, even though unproven, the service has significant potential as an effective treatment for that Sickness or condition.
- The decision about whether an Unproven Service is considered to be a Covered Health Service is solely at UnitedHealthcare's discretion.

Urgent Care - care that requires prompt attention to avoid adverse consequences, but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

SECTION 15 - OUTPATIENT PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drug Products.
- How to utilize the retail and mail order service for obtaining Prescription Drug Products.
- Any Benefit limitations and exclusions that exist for Prescription Drug Products.
- Definitions of terms used throughout this section related to the Prescription Drug Product Plan.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List (PDL) the Prescription Drug Product is listed. Prescriptions filled at a pharmacy that is not a Network Pharmacy are not covered by the Plan. Refer to the Outpatient Prescription Drug Schedule of Benefits for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

What You Must Pay

CDHP Option

If you are enrolled in the CDHP option, you must satisfy your Annual Deductible before the Plan pays any amount towards prescription drugs. However, the Plan will pay for a prescription drug that is a Preventive Care Medication even if you have not met the Deductible. See *Benefits for Preventive Care* below. Once the Annual Deductible is met, you are then responsible for the applicable Copayment/Coinsurance until your Out-of-Pocket Limit is met. Once your Out-of-Pocket Limit is met, the Plan pays 100%. Any coupons or discount offers from pharmaceutical companies or their affiliates are not treated as payments by you and do not count towards your Annual Deductible or your Out-of-Pocket Limit.

Prescription Drug Out-of-Pocket Limits

For Health 1 and Health 2 there are separate Out-of-Pocket Limits for prescription drug Copayments/Coinsurance. For Health 1 there is an individual Out-of-Pocket Limit of $5,600 and a family Out-of-Pocket Limit of $11,200 for prescription drug Copayments/Coinsurance. For Health 2 there is an individual Out-of-Pocket Limit of $4,100 and a family Out-of-Pocket Limit of $9,200 for prescription drug Copayments/Coinsurance. Once the Out-of-Pocket Limit is reached, your prescriptions will be covered at 100% of eligible expenses. The prescription drug Out-of-Pocket Limits for Health 1 and Health 2 are embedded limits, so once a Covered Person reaches the applicable individual amount, prescriptions are covered 100% for that Covered Person.

There is no separate Out-of-Pocket Limit for prescription drug Copayments/Coinsurance for the CDHP option. Instead, for the CDHP option prescription drug Copayments/Coinsurance are counted towards the regular Out-of-Pocket Limit. Any coupons or discount offers from pharmaceutical companies or their affiliates are not treated as payments by you and do not count towards your Out-of-Pocket Limit.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your request and there is another drug that is Chemically Equivalent. See the definition of Ancillary Charge below in this Section 15.

Payment Terms and Features - Outpatient Prescription Drugs

Prescription Drug Product Coverage Highlights

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

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug Product becomes available as a Generic drug, the tier placement of the Brand-name Prescription Drug Product may change and an Ancillary Charge may apply if you request the Brand-name Prescription Drug Product in lieu of the Generic version of the Prescription Drug Product. In addition, your Copayment and/or Coinsurance may greater if the prescription is filled with the Brand-name version of the Prescription Drug Product. You will pay the Copay and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare or its designee. The reason for obtaining prior authorization from UnitedHealthcare or its designee is to determine if the Prescription Drug Product, in accordance with UnitedHealthcare's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service as defined by the Plan.
- It is not an Experimental or Investigational or Unproven Service, as defined in Section 14, *Glossary*.

If you do not obtain prior authorization from UnitedHealthcare before the Prescription Drug Product is dispensed, you can ask UnitedHealthcare to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from UnitedHealthcare before the Prescription Drug Product was dispensed.

The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

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

To determine if a Prescription Drug Product requires prior authorization, either visit **www.myuhc.com** or call the number on your ID card. The Prescription Drug Products requiring prior authorization are subject to UnitedHealthcare's periodic review and modification.

Schedule of Benefits - Outpatient Prescription Drugs

This table provides an overview of your cost sharing responsibility under the Plan for Outpatient Prescription Drugs. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Benefit Information for Prescription Drug Products at a Network Pharmacy

Benefit[1,2] **Description and Supply Limits**	**Percentage of Prescription Drug Charge Payable by you per Prescription Order or Refill:**
Your Copayment and/or Coinsurance is determined by the tier to which the UnitedHealthcare Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List (PDL) are assigned to Tier 1, Tier 2 or Tier 3. Please access **www.myuhc.com** through the Internet or call the telephone number on your ID card to determine tier status.	
Retail –As written by the provider, up to a consecutive 90-day supply. ■ Tier-1 and Tier-2 - 1 to 31-day supply - 32 to 60-day supply - 61 to 90-day supply	 20%, However, you will not pay less than $10 (or the actual price of the drug, if less) and you will not pay more than $50. 20%, However, you will not pay less than $20 (or the actual price of the drug, if less) and you will not pay more than $100. 20%, However, you will not pay less than $30 (or the actual price of the drug, if less) and you will not pay more than $150.

Benefit[1,2] **Description and Supply Limits**	**Percentage of Prescription Drug Charge Payable by you per Prescription Order or Refill:**
■ Tier-3	
- 1 to 31-day supply	50%, However, you will not pay less than $10 (or the actual price of the drug, if less) and you will not pay more than $50.
- 32 to 60-day supply	50%, However, you will not pay less than $20 (or the actual price of the drug, if less) and you will not pay more than $100.
- 61 to 90-day supply	50%, However, you will not pay less than $30 (or the actual price of the drug, if less) and you will not pay more than $150.
Specialty Prescription Drug Products - As written by the provider, up to a consecutive 90-day supply. Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy. ■ Tier-1, Tier-2 and Tier-3	
- 1 to 31-day supply	50%, However, you will not pay less than $10 (or the actual price of the drug, if less) and you will not pay more than $50.
- 32 to 60-day supply	50%, However, you will not pay less than $20 (or the actual price of the drug, if less) and you will not pay more than $100.
- 61 to 90-day supply	50%, However, you will not pay less than $30 (or the actual price of the drug, if less) and you will not pay more than $150.
Mail Order Network Pharmacy - As written by the provider, up to a consecutive 90-day supply.	
■ Tier-1 and Tier-2	20%, However, you will not pay less than $20 (or the actual price of the drug, if less) and you will not pay more than $100.
■ Tier-3	50%, However, you will not pay less than $20 (or the actual price of the drug, if less) and you will not pay more than $100.

Benefit[1,2] Description and Supply Limits	Percentage of Prescription Drug Charge Payable by you per Prescription Order or Refill:
HIV/AIDS/Transplant drugs (90-day supply for retail or mail order)	
■ Tier-1 and Tier-2	20%, However, you will not pay less than $20 (or the actual price of the drug, if less) and you will not pay more than $100.
■ Tier-3	50%, However, you will not pay less than $20 (or the actual price of the drug, if less) and you will not pay more than $100.
Preventive vaccines including Influenza	$0 Copay

[1]Please obtain prior authorization from UnitedHealthcare before receiving Prescription Drug Products, as described in *Payment Terms and Features,* under *Prior Authorization Requirements* in this section.

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

[3]If Walgreen's90 Saver applies, you may obtain a 90 day supply of Maintenance Medications from a Preferred 90 Day Retail Partner.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drug Products as described in this section. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by UnitedHealthcare 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.

You may seek reimbursement from the Plan as described in Section 9, *Claims Procedures*, under the heading, *If Your Provider Does Not File Your Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any Deductible that applies.

Submit your claim to:

Optum Rx Claims Department
PO Box 650334
Dallas, TX 75265-0334

Benefit Levels

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

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drug Products. All Prescription Drug Products covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the UnitedHealthcare Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the 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:

- Tier-1 is your lowest Coinsurance 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 Coinsurance option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Coinsurance option. 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. However, there is also a minimum Copayment amount and a maximum Copayment amount. See the table at the beginning of this section for the applicable minimum and maximum Copayment amounts.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of:

- The applicable Copay or Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.
- The Prescription Drug Charge for that Prescription Drug Product.

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

- The applicable Copay or Coinsurance.
- The Prescription Drug Charge for that particular Prescription Drug.

Variable Copayment Program: Certain Prescription Drug Products, including certain Specialty Prescription Drug Products may be eligible for copayment assistance programs which can lower your Copayment or Coinsurance. See Variable Copayment Program below.

If you are enrolled in the CDHP option, you will need to satisfy the Annual Deductible before the Plan pays any amount towards Prescription Drug Products (except for Prescription Drug Products that are Preventive Care Medications).

Variable Copayment Program

Certain Prescription Drug Products may be eligible for copayment assistance through programs established by drug manufacturers ("copayment assistance programs"). Typically, copayment assistance programs will provide a coupon to offset a portion of the cost of the drug, often requiring the patient to pay a nominal fee.

If you are enrolled in the Health 1 option or Health 2 option, participation in a copayment assistance program may help reduce what you pay for the Prescription Drug Product under the Plan. UnitedHealthcare can help you determine whether your Prescription Drug Product is eligible for copayment assistance through a copayment assistance program. If your Prescription Drug Product is eligible for a copayment assistance program and if you elect to participate in it, your Copayment will be based on the amount of assistance available through the coupon, but your out-of-pocket cost will be limited to any nominal fee you had to pay. Consider the following example:

Example – John is enrolled in the Health 1 option and has a prescription for a Prescription Drug Product for which there is copayment assistance program. Normally John would have a $50 Copayment under the Plan for his 30-day prescription. John contacts UnitedHealthcare and learns there is a copayment assistance program for the Specialty Prescription Drug Product. Under that copayment assistance program John will receive a coupon which requires him to pay $5 for his prescription. John, with the assistance of UnitedHealthcare, enrolls in that copayment assistance program and uses the coupon when paying for his prescription. The $5 payment John makes using the coupon will count towards his Out-of-Pocket Limit.

Please contact UnitedHealthcare at www.myuhc.com or the telephone number on your ID card for a list of Prescription Drug Products that may be available for copayment assistance.

If you choose not to participate, you will pay the applicable Copayment or Coinsurance as described in the *Schedule of Benefits - Outpatient Prescription Drugs*.

The amount of any copayment assistance you receive through one of these programs will not count toward any applicable Deductible or Out-of-Pocket Limit.

The Variable Copayment Program described herein is not available for participants enrolled in the CDHP option or either Medicare Supplement option.

Retail

Benefits are provided for Prescription Drug Products only if they are dispensed by a Network Pharmacy. 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 number on your ID card or by logging onto **www.myuhc.com**.

To obtain your prescription from a retail Network Pharmacy, simply present your ID card and pay the Copay and/or Coinsurance. The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. If Walgreen's90 Saver applies, you may be eligible for a 90 day supply at a Preferred 90 Day Retail Partner.

When a Prescription Drug Product, including a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay and/or Coinsurance that applies will reflect the number of days dispensed or days the drug will be delivered or days the drug will be delivered.

If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

Note: Network 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

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy. The mail order service may allow you to purchase up to a 90-day supply of a covered Prescription Drug Product through the mail from a Network Pharmacy.

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 number on your ID card.

The following supply limits apply: As written by the provider, 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 Product 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 and/or 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 include those for Preventive Care Medications as defined, in this section, under *Glossary - Prescription Drug Products*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card.

GLP-1 Drug Products for Weight Loss

For a GLP-1 Drug Product that is prescribed for weight loss to be covered under the Plan you must be enrolled in the Virta virtual weight-loss clinic and the GLP-1 Drug Product must be prescribed by a Virta provider. A GLP-1 Drug Product that is prescribed for Type 2 diabetes is not subject to these requirements.

Your Right to Request an Exclusion Exception

You or your provider can submit a request for an exclusion exception for a drug that is not on the Plan's formulary. To request an exception, submit a letter to UnitedHealthcare from your provider stating the medical condition that requires the non-covered drug, the length of projected use of the drug and clinical criteria supporting the therapy needed. An exception may be granted for up to 12 months. If your exception is approved, you will be able to purchase your prescription at your local network pharmacy or Optum Home Delivery by paying the applicable copay or coinsurance amount. Any applicable plan deductible will also apply. Your provider can submit the exception request via the UHCProvider.com portal. Should the duration of medication need extend the maximum 12 month period, the exception process will need to be completed again to confirm continued medical necessity for use of the drug.

If you or your provider are not satisfied with UnitedHealthcare's determination of your exclusion exception request, you can file an appeal of that decision.in accordance with *How to Appeal a Denied Claim* in Section 9 *Claims Procedures*. This may include the right to file an External Review or an Expedited External Appeal.

Note: For more information see Section 9, *How to Appeal a Denied Claim, External Review Program* and *Expedited External Appeal.*

Your Right to Request an Exception for Contraceptives

An exception process applies to certain contraceptive Preventive Care Medications if your Physician determines that a Prescription Drug Product alternative to the contraceptive Preventive Care Medication is Medically Necessary for you.

An expedited medication exception request may be available if the time needed to complete a standard exception request could significantly increase the risk to your health or ability to regain maximum function.

If a request for an exception is approved by the Claims Administrator, Benefits provided for the Prescription Drug Product will be treated the same as Benefits for the Preventive Care Medication.

For more information, please visit www.uhcprovider.com under the following path: *Resources_Drug Lists and Pharmacy_Additional Resources_Patient Protection and Affordable Care Act $0 Cost-Share Preventive Medications Exemption Requests (Commercial Members).*

Designated Pharmacy

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drug Products.

For certain Specialty Prescription Drug Products (see below), if you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, UnitedHealthcare may direct you to a Designated Pharmacy with whom UnitedHealthcare has an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, no Benefit will be paid for that Specialty Prescription Drug Product.

Please see *Glossary - Outpatient Prescription Drugs*, for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Want to lower your out-of-pocket Prescription Drug Product costs?
Consider tier-1 Prescription Drug Products, if you and your Physician decide they are appropriate.

Assigning Prescription Drug Products to the Prescription Drug List (PDL)

UnitedHealthcare's Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on UnitedHealthcare's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

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

The PDL Management Committee may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

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

Note: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access **www.myuhc.com** through the Internet or call the number on your ID card for the most up-to-date tier status.

Prescription Drug Product, 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.

Prescription Drug Benefit Claims

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

Limitation on Selection of Pharmacies

If UnitedHealthcare determines that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, UnitedHealthcare may require you 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, UnitedHealthcare will select a single Network Pharmacy for you.

Supply Limits

Benefits for Prescription Drug Products are subject to supply limits that are stated in the table under the heading *Prescription Drug Product Coverage Highlights*. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit. Whether or not a Prescription Drug Product 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 UnitedHealthcare 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 or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing, through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

Special Programs

Erie Insurance 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 your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the directed Mail Order Network Pharmacy, you will pay an increased cost share.

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy or Preferred 90 Day Retail Partner to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the directed Mail Order Network Pharmacy or Preferred 90 Day Retail Partner, you will pay an increased cost share after the allowed number of fills at Retail Network Pharmacy.

Prescription Drug Products that are Chemically Equivalent

If two drugs are Chemically Equivalent (they contain the same active ingredient) and you or your Physician choose not to substitute for this lower priced Chemically Equivalent drug for the higher priced drug, you will pay the difference between the higher priced drug and the lower priced Chemically Equivalent drug, in addition to the Copayment and/or Coinsurance.

This difference in cost is called an Ancillary Charge. An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower price.

Coupons, Incentives and Other Communications

At various times, UnitedHealthcare may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Price Edge Cost List

The *Price Edge Cost (PEC) List* is a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes when a Prescription Drug Product is obtained from a retail Network Pharmacy or a mail order Network Pharmacy. This list is subject to the Claims Administrator's review and may change from time to time. When a Generic Prescription Drug Product is included on the *PEC List* and is dispensed by a retail Network Pharmacy or a mail order Network Pharmacy, the *PEC List* price will only apply when the *PEC List* price is the lowest cost option for the Covered Person. You may access the amount you will pay for Prescription Drug Products to be dispensed by a retail Network Pharmacy or a mail order Network Pharmacy by contacting UnitedHealthcare at **www.myuhc.com** or by calling the number on your ID card.

Exclusions - What the Plan Will Not Cover

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

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

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 Product 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. A Pharmaceutical Product for which Benefits are provided in the medical (not in Section 15, *Outpatient Prescription Drugs*) portion of the Plan.

This includes certain forms of vaccines/immunizations. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. Available over-the-counter medications that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless otherwise specifically covered under the Plan

5. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* 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 Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3).

6. Prescription Drug Products obtained from a non-Network Pharmacy. This exclusion does not apply to Prescription Drug Products dispensed outside the United States in an Emergency.

7. Prescription Drug Products dispensed outside of the United States, except in an Emergency.

8. Durable Medical Equipment for which Benefits are provided in this *SPD*. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies, including certain insulin pumps and related supplies for the management and treatment of diabetes, and inhaler spacers specifically stated as covered.

9. Certain Prescription Drug Products for tobacco cessation.

10. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition). This exclusion does not apply if, after review, it is determined by the prescriber specialty to be appropriate for a specific growth deficiency with diagnosis of a medical condition causing the deficiency.

11. The amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

12. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and placed on a tier by the Claims Administrator's Prescription Drug List (PDL) Management Committee.

13. Prescribed, dispensed or intended for use during an Inpatient Stay.

14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that UnitedHealthcare and Erie Insurance determines do not meet the definition of a Covered Health Service.

15. A Prescription Drug Product that is not on the Prescription Drug List (PDL). The UnitedHealthcare Prescription Drug List (PDL) Management Committee makes determinations on Prescription Drug Products up to six times during a calendar year.

When a change is made to add a previously excluded Prescription Drug Product to the Prescription Drug List (PDL), UnitedHealthcare may decide at any time to retroactively reinstate Benefits for that Prescription Drug Product.

16. A Prescription Drug Product that is on the Prescription Drug List (PDL) for one or more specific approved medical conditions, but which was prescribed for a medical condition for which the Prescription Drug Product was not approved. The UnitedHealthcare Prescription Drug List (PDL) Management Committee makes determinations on Prescription Drug Products up to six times during a calendar year. When a change is made to approve a Prescription Drug Product for a medical condition for which it previously was not approved, UnitedHealthcare may decide at any time to retroactively reinstate Benefits for that Prescription Drug Product for that newly approved medical condition.

17. Certain unit dose packaging or repackagers of Prescription Drug Products, unless unit dose packaging is the only available form.

18. Used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Erie Insurance have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*.

19. Used for cosmetic or convenience purposes

20. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

21. General vitamins, except for the following which require a Prescription Order or Refill:

    - Prenatal vitamins.
    - Vitamins with fluoride.
    - Single entity vitamins.

22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products, even when used for the treatment of Sickness or Injury.

23. A Prescription Drug Product that contains marijuana, including medical marijuana.

24. Diagnostic kits and products including associated services.

25. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

26. Certain Prescription Drug Products that are FDA approved as a package with a device or application, including smart package sensors and/or embedded drug sensors. This exclusion does not apply to a device or application that assists you with the administration of a Prescription Drug Product.

27. Drugs whose intended use is illegal, unethical, imprudent, abusive, or otherwise improper.

28. Services or supplies not legally provided.

Glossary - Outpatient Prescription Drugs

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available. For example, an Ancillary Charge may apply if your provider prescribes a Prescription Drug Product without regard to whether the prescription is to be filled with the Brand name of that Prescription Drug Product or the Generic equivalent of that Prescription Drug Product and you request the prescription be filled with the Brand name Prescription Drug Product. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Product Charge for the Prescription Drug Product, and the Prescription Drug Product Charge for the Chemically Equivalent Prescription Drug Product.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that UnitedHealthcare identifies as a Brand-name product, based on available data resources including, but not limited to, Medi-Span or First DataBank, that classify drugs as either brand or generic based on a number of factors. A product identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by UnitedHealthcare.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drug Products including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that UnitedHealthcare identifies as a Generic product based on available data resources including, but not limited to, Medi-Span or First DataBank, that classify drugs as either brand or generic based on a number of factors. A product identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by UnitedHealthcare.

GLP-1 Drug Product - A class of medications that mainly help manage blood sugar (glucose) levels in people with Type 2 diabetes. Some GLP-1 medications can also help treat obesity.

GLP-1 medications are most often injectable medications, meaning you inject a liquid medication with a needle and syringe. Other names for this medication class include:

- Glucagon-like peptide-1 agonists.
- GLP-1 receptor agonists.
- Incretin mimetics.
- GLP-1 analogs.

GLP-1 medications alone can't treat Type 2 diabetes or obesity. Both conditions require other treatment strategies, such as lifestyle and dietary changes.

List of Preventive Medications (for CDHP Plan only) - a list that identifies certain Prescription Drug Products, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List (PDL) that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Mail Order Network Pharmacy - a mail order pharmacy that is a Network Pharmacy.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that UnitedHealthcare establishes. This list is subject to UnitedHealthcare's periodic review and modification.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with UnitedHealthcare or an organization contracting on its behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by UnitedHealthcare as a Network Pharmacy.

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

- The date it is assigned to a tier by UnitedHealthcare's Prescription Drug List (PDL) Management Committee.
- December 31st of the following calendar year.

Out-of-Pocket Drug Limit - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the Outpatient Prescription Drug Benefit Information table for details about how the Out-of-Pocket Drug Limit applies. The Out-of-Pocket Drug Limit applies only to enrollees in Health 1 and Health 2.

Preferred 90 Day Retail Partner - a retail Network Pharmacy that UnitedHealthcare identifies as a preferred pharmacy for Maintenance Medications.

Prescription Drug Charge - the rate the Plan has agreed to pay UnitedHealthcare on behalf of its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration*. This list is subject to UnitedHealthcare's 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 Product has been assigned by contacting UnitedHealthcare at the 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 Drug Products into specific tiers.

Prescription Drug Product - a medication, or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of Benefits under this Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
  - Standard insulin syringes with needles.
  - Blood-testing strips - glucose.
  - Urine-testing strips - glucose.
  - Ketone-testing strips and tablets.
  - Lancets and lancet devices.
  - Insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets.
  - Glucose meters including continuous glucose monitors.
- Certain vaccines/immunizations administered in a Network Pharmacy.
- Certain injectable medications administered in a Network Pharmacy.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications (PPACA Zero Cost Share) - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the Prescription Drug Charge (without application of any

Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force.*
- 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.*
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration.*

You may determine whether a drug is a Preventive Care Medication as well as information on access to coverage of Medically Necessary alternatives through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the number on your ID card.

For the purposes of this definition PPACA means Patient Protection and Affordable Care Act of 2010, as amended.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. Specialty Prescription Drug Products may include drugs on the List of Preventive Medications. You may access a complete list of Specialty Prescription Drug Products through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Usual and Customary Charge - the usual fee that a pharmacy charges an individual for a Prescription Drug Product 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, including your rights under ERISA.

This section includes information on the administration of the Plan, as well as information required of all Summary Plan Descriptions by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Erie Indemnity Company is the Plan Sponsor of the Erie Indemnity Company Health Protection Plan.

The committee appointed by the Vice President, Corporate HR of Erie Insurance (or, if there is no person holding that title, the person holding a successor title or acting in a similar capacity with respect to the oversight of the welfare benefit plans maintained by Erie Insurance) is the Plan Administrator of the Erie Indemnity Company Health Protection Plan and has the discretionary authority to interpret the Plan. This committee is referred to as the Employee Benefits Administration Committee. You may contact the Plan Administrator at:

Erie Indemnity Company
Employee Benefits Administration Committee
100 Erie Insurance Place
Erie, PA 16530
(814) 870-2000

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage, through an administrative services agreement with the Company.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Erie Indemnity Company
Law Division
100 Erie Insurance Place
Erie, PA 16530
(814) 870-2000

Legal process may also be served on the Plan Administrator.

Participating Affiliates of Erie Insurance

Erie Insurance Company of New York and Erie Resources Management Corp.

Rebates

If Erie Insurance (including a related company) receives a refund, rebate, dividend, experience adjustment, or other similar payment ("Rebate") related to the Plan, the Rebate will be considered attributable to Erie Insurance contributions towards the cost of coverage. Only if the amount of the Rebate exceeds the total amount of Erie Insurance contributions towards the cost of coverage will the Rebate be considered attributable to Employee contributions, in which case, only the portion of the Rebate that exceeds the total amount of Erie Insurance contributions shall be considered attributable to Employee contributions. Erie Insurance may retain all or a portion of a Rebate attributable to Erie Insurance contributions. Erie Insurance will use or distribute Rebates attributable to Employee contributions in a manner consistent with applicable law.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare plan and the administration is provided through one or more third party administrators.

Plan Name:	Erie Indemnity Company Health Protection Plan
Plan Number:	501
Employer ID:	25-0466020
Plan Type:	Welfare benefits plan
Plan Year:	January 1 - December 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- Receive information about the Plan and Benefits.

- Examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents - including pertinent insurance contracts, collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual report (Form 5500 series) and updated Summary Plan Descriptions. The Plan Administrator may make a reasonable charge for copies.
- Receive a copy of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration*, *U.S. Department of Labor*, listed in your telephone directory, or write to the *Division of Technical Assistance and Inquiries*, *Employee Benefits Security Administration*, *U.S. Department of Labor*, 200 Constitution Avenue NW Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the *Employee Benefits Security Administration* at (866) 444-3272.

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 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 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*, the Plan provides 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.
- 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 prior authorization or notify the Claims Administrator. For information on notification or prior authorization, contact your issuer.

ADDENDUM – REAL APPEAL

This Addendum to the Plan provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Real Appeal

The Plan provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons 18 years of age or older. Real Appeal is designed to help those at risk from obesity-related diseases.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching with a live virtual coach and online group participation with supporting video content. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but is not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like information regarding these Covered Health Services, you may contact the Claims Administrator through **www.realappeal.com**, or at the number shown on your ID card.