SUMMARY PLAN DESCRIPTION

ASCEN WORKFORCE, LLC
WELFARE BENEFIT PLAN

7800-000152

FLEXWORK BASIC RX 25

Summary Plan Description

ASCEN WORKFORCE, LLC Welfare Benefit Plan

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Section 1: Welcome

ASCEN WORKFORCE, LLC 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 ASCEN WORKFORCE, LLC Welfare Benefit Plan. It includes summaries of:

- Who is eligible;
- Services that are covered, called Covered Health Care 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 supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT
The healthcare service, supply or Pharmaceutical Product is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in Section 12: *Defined Terms*.) 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 disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Plan.

Can this Plan Change?

ASCEN WORKFORCE, LLC intends to continue this Plan, but reserves the right, as they determine, 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.

United HealthCare Services, Inc. is a private healthcare claims administrator whose goal is to give you the tools you need to make wise healthcare decisions. United HealthCare Services, Inc. also helps your employer to administer claims. Although United HealthCare Services, Inc. will assist you in many ways, it does not guarantee any Benefits. ASCEN WORKFORCE, LLC is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the ASCEN WORKFORCE, LLC Welfare Benefit Plan works. If you have questions, contact your Employer or call the number on the back of your ID card.

What Are Defined Terms?

Certain capitalized words have special meanings. The Plan Sponsor has defined these words in Section 12*: Defined Terms*.

When the Plan Sponsor uses the words "you" and "your," the Plan Sponsor is referring to people who are Covered Persons, as that term is defined in Section 12: *Defined Terms*.

How Do You Use This SPD?

Read your entire SPD and any attached Amendments, or Addendums. You may access the most current version of your SPD and any future amendments at flexwork.uhc.com.

Review the Benefit limitations of this SPD by reading the attached Schedule of Benefits along with Section 1: *Covered Health Care Services* and Section 2: *Exclusions and Limitations*. Read Section 8: *General Legal Provisions* to understand how this SPD and your Benefits work. Call the Claims Administrator if you have questions about the limits of the coverage available to you.

If there is a conflict between this SPD and any summaries provided to you by the Plan Sponsor, this SPD controls.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

How Do You Contact the Claims Administrator?

Call the telephone number listed on your identification (ID) card. Throughout the document you will find statements that encourage you to contact the Claims Administrator for more information.

Your Responsibilities

Enrollment and Required Contributions
Benefits are available to you once you are enrolled for coverage under the Plan. The Plan Sponsor will apply the eligibility rules. Your enrollment options, and the corresponding dates that coverage begins, are listed in Section 2: *When Coverage Begins*. To be enrolled and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the rules of the Plan issued to your Plan Sponsor, including the eligibility rules.
- You must qualify as a Participant or a Dependent as those terms are defined in Section 12: *Defined Terms*.
- You continue to receive Benefits as long as you continue to qualify as a Participant or Dependent as defined in Section 12: *Defined Terms* and meet the eligibility rules.
- Your Benefits are no longer available as described in Section 3: *When Coverage Ends*.

Your Plan Sponsor may require you to make certain payments to them, in order for you to remain enrolled under the Plan. If you have questions about this, contact your Plan Sponsor.

Be Aware the Plan Does Not Pay for All Health Care Services
The Plan does not pay for all health care services. Benefits are limited to Covered Health Care Services. The *Schedule of Benefits* will tell you the portion you must pay for Covered Health Care Services.

Decide What Services You Should Receive
Care decisions are between you and your Physician. The Claims Administrator and the Plan Sponsor do not make decisions about the kind of care you should or should not receive.

Choose Your Physician
It is your responsibility to select the health care professionals who will deliver your care. The Claims Administrator arranges for Physicians and other health care professionals and facilities to participate in a Network. The Claims Administrator's credentialing process confirms public information about the professionals' and facilities' licenses and other credentials but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Pay Your Share
You must meet any applicable Copayments or Coinsurance for most Covered Health Care Services. Additionally some Covered prescription medication requires Coinsurance if your Plan has a specific Pharmacy benefit. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable Copayment or Coinsurance amounts are listed in the *Schedule of Benefits*.

Pay the Cost of Excluded Services
You must pay the cost of all excluded services and items. Review Section 6: *Exclusions and Limitations* to become familiar with the Plan's exclusions.

Show Your ID Card
You should show your ID card every time you request health care services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered.

File Claims with Complete and Accurate Information
When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Plan. You must file the claim in a format that contains all of the information the Claims Administrator requires to process the claim, as described in Section 7: *How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, Benefits for that particular condition or disability are subject to your previous carrier's obligation under state law or contract.

Claims Administrator Responsibilities

Determine Benefits
The Claims Administrator makes administrative decisions regarding whether the Plan will pay for any portion of the cost of a health care service you intend to receive or have received. The Claims Administrator's decisions are for payment purposes only. The Claims Administrator does not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

The Claims Administrator has the discretion to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this SPD, the *Schedule of Benefits* and any Amendments.
- Make factual determinations relating to Benefits.

The Claims Administrator may assign this authority to other persons or entities including Claims Administrator's affiliates that may provide administrative services for the Plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time at the Claims Administrator's discretion. In order to receive Benefits, you must cooperate with those service providers.

Process Payment for the Plan's Portion of the Cost of Covered Health Care Services
The Claims Administrator processes the Plan's payment of Benefits for Covered Health Care Services as described in Section 5: *Covered Health Care Services* and in the *Schedule of Benefits*, unless the service is excluded in Section 6: *Exclusions and Limitations*. This means the Claims Administrator processes only the payment of the Plan's portion of the cost of Covered Health Care Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by the Plan.

Process Plan Payment to Network Providers
It is the responsibility of Network Physicians and facilities to file for payment from the Plan. When you receive Covered Health Care Services from Network providers, you do not have to submit a claim to the Plan.

Process Plan Payment for Covered Health Care Services Provided by Out-of-Network Providers
The Claims Administrator processes the Plan's payment of Benefits after receiving your request for payment that includes all required information. See Section 7: *How to File a Claim*.

Review and Determine Benefits in Accordance with the Claims Administrator's Reimbursement Policies
The Claims Administrator adjudicates claims consistent with industry standards. The Claims Administrator develops its reimbursement policy guidelines, as the Claims Administrator determines, generally in accordance with one or more of the following methodologies:

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

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), the Claims Administrator's reimbursement policies are applied to provider billings. The Claims Administrator shares its reimbursement policies with Physicians and other providers in the Claims Administrator's Network through the Claims Administrator's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by the Claims Administrator's reimbursement policies) and the billed charge. However, out-of-Network providers may bill you for any amounts the Plan does not pay, including amounts that are denied because one of the Claims Administrator's reimbursement policies does not reimburse (in whole or in part) for the service billed.

Section 2: When Coverage Begins

Who is Eligible for Coverage?

Eligible Person

Eligible Person usually refers to an employee of the Plan Sponsor who (or other person whose connection with the Plan Sponsor) meets the applicable eligibility rules. When an Eligible Person enrolls, the Claims Administrator refers to that person as a Participant. For a complete definition of Eligible Person, Plan Sponsor and Participant, see Section 12*: Defined Terms*.

Eligible Person usually refers to an employee or member of the Group who meets the eligibility rules. When an Eligible Person enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see Section 12: *Defined Terms*.

Eligible Persons must reside within the United States. An employee residing in Hawaii is not an Eligible Person.

Dependent

Dependent generally refers to the Participant's spouse and children. When a Dependent enrolls, the Claims Administrator refers to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see Section 12: *Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan.

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

- Your Spouse, as defined in Section 12: *Defined Terms*.
- Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
- An unmarried child age 26 or over who is or becomes disabled and dependent upon you. A child is no longer eligible as a Dependent when the child reaches age 26 except as provided in Section 3: *When Coverage Ends* under *Coverage for a Disabled Dependent Child.*

***Note*:** If you and your Spouse are both covered under the ASCEN WORKFORCE, LLC Welfare Benefit Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the ASCEN WORKFORCE, LLC Welfare Benefit Plan, only one parent may enroll your child as a Dependent.

- A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order (QMCSO)* or other court or administrative order, as described in Section 9: *Other Important Information*.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Claims 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.

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

Cost of Coverage

You and ASCEN WORKFORCE, LLC share in the cost of the Plan. Your contribution amount depends on the Plan you select and the eligible dependents you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

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

Your contributions are subject to review and ASCEN WORKFORCE, LLC reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by contacting the Plan Sponsor.

How Do You Enroll?

Eligible Persons must use the enrollment process established by the Plan Sponsor during the initial Open Enrollment Period and during any annual Open Enrollment Period. The Plan Sponsor or its benefits administration vendor will submit the enrollment to the Claims Administrator, along with any required contribution. The Plan will not provide Benefits for health care services that you receive before your effective date of coverage.

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

Each year during the annual Open Enrollment Period, you have the opportunity to review and change your medical election. Any changes you make during the Open Enrollment Period will become effective as of the Plan's anniversary renewal date.

Important: See the *New Eligible Person, Adding New Dependents, and Special enrollment Period* sections below if you wish to make allowed coverage changes due to your marriage, birth, adoption of a child, placement for adoption of a child or other eligible family status change, and you must contact the Plan Sponsor within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Do You Enroll and When Does Coverage Begin?

Eligible Persons generally enroll during the 31 days prior to the Initial Enrollment Period and any annual Open Enrollment Period. Except as described in this Section 2: *When Coverage Begins*, Eligible Persons may not enroll themselves or their Dependents.

Coverage begins on the effective date shown in the Plan and on each anniversary of the effective date.

Initial Enrollment Period

When the Plan Sponsor purchases coverage under the Plan from the Claims Administrator, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date shown in the Plan. The Plan Sponsor and Claims Administrator must receive the completed electronic file and any required contribution within 31 days of the date the Eligible Person becomes eligible.

Open Enrollment Period

Period determined by the Plan Sponsor prior to the renewal date of the Plan during which Eligible Persons can enroll themselves and their Dependents under the Plan.

The Plan Sponsor and Claims Administrator must receive the completed electronic file and any required contribution within the open enrollment period.

New Eligible Persons

Coverage for a new Eligible Person and eligible Dependents begins on the date agreed to by the Plan Sponsor in accordance with the eligibility rules. The Plan Sponsor and Claims Administrator must receive the completed electronic file and any required contribution within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Participants may enroll new Dependents due to any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.
- Registering a Domestic Partner.
- Your eligible dependent moves to the United States. This is for first time enrollment only. Re-entry to the United States after an extended leave outside of the United States is not a qualifying event for enrollment.

Coverage for the Dependent begins on the date of the event. The Plan Sponsor and Claims Administrator must receive the completed electronic file and any required contribution within 31 days of the event.

Special Enrollment Period

An Eligible Person and/or eligible Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan ended for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or eligible Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment rights are available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person, Spouse and any newly acquired Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Registering a Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if any of the following are true:

- The Eligible Person previously declined coverage under the Plan, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if the Plan Sponsor receives the completed electronic file and any required contribution within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period and coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer resides, lives or works in an HMO service area if no other benefit option is available.
  - The plan no longer offers benefits to a class of individuals that includes the Eligible Person and/or Dependent.
  - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP).* Coverage will begin only if the Plan Sponsor and Claims Administrator receives the completed enrollment form and any required contribution within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event. The Plan Sponsor and Claims Administrator must receive the electronic file and any required contribution within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if the Plan Sponsor and Claims Administrator receive the electronic file and any required contribution within 31 days of the date coverage under the prior plan ended.

Late Enrollees for Medical Coverage

If the Claims Administrator receives your enrollment after the applicable Initial Enrollment Period or a special enrollment period, you are a Late Enrollee (Refer to Section 12: *Defined Terms)*. If you are a Late Enrollee, your enrollment may be postponed until the next Open Enrollment Period or a special enrollment period as described above.

Section 3: When Coverage Ends

General Information about When Coverage Ends

As permitted by law, the Plan Sponsor may end the Plan and/or all similar benefit plans at any time for the reasons explained in the Plan.

Your right 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 Claims Administrator will still process Plan payments on claims for Covered Health Care Services that you received before the date your coverage ended. However, once your coverage ends, the Claims Administrator will not process Plan payments on claims for any health care services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Participant's coverage ends.

What Events End Your Coverage?

Coverage ends on the earliest of the dates specified below:

- **The Entire Plan Ends**

  Your coverage ends on the date the Plan ends. In this event, the Plan Sponsor is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

  Your coverage ends on the date you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to Section 12*: Defined Terms* for definitions of the terms **"Eligible Person," "Participant," "Dependent" and "Enrolled Dependent."** Coverage for your Enrolled Dependent child ends on the last day of the month in which your Enrolled Dependent child no longer qualifies as a Dependent under this Plan.

- **The Claims Administrator Receives Notice to End Coverage**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends on the date the Claims Administrator receives the required notice from the Plan Sponsor to end your coverage, or on the date requested in the notice, if later.

- **Participant Retires or Is Pensioned**

  The Plan Sponsor is responsible for providing the required notice to the Claims Administrator to end your coverage. Your coverage ends the date the Participant is retired or pensioned.

Fraud or Intentional Misrepresentation of a Material Fact

The Plan will provide at least 30 days advance required notice to the Participant that coverage will end on the date identified in the notice because you committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent. You may appeal this decision during the notice period. The notice will contain information on how to appeal the decision.

If the Claims Administrator and the Plan Sponsor find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact the Plan Sponsor has the right to demand that you pay back all Covered Health Care Services the Plan paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. The Plan will extend the coverage for that child beyond this age if both of the following are true:

- The Enrolled Dependent child is not able to support him/her self because of mental, developmental or physical disability.
- The Enrolled Dependent child depends mainly on the Participant for support.

Coverage will continue, as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage otherwise ends in accordance with the terms of the Plan.

You must furnish the Plan with proof of the medical certification of disability within 31 days of the date coverage would have ended because the child reached a certain age. Before the Plan agrees to this extension of coverage for the child, the Plan may require that a Physician chosen by the Plan examine the child. The Plan will pay for that examination.

The Plan may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at the Plan's expense. The Plan will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of the Plan's request as described above, coverage for that child will end.

Continuation of Coverage

If your coverage ends under the Plan, you may have the right to elect continuation coverage (coverage that continues on in some form) in accordance with federal law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) only applies to Plan Sponsors that are subject to the terms of COBRA. Contact your Plan Administrator to find out if ASCEN WORKFORCE, LLC is subject to the provisions of COBRA.

If you chose continuation coverage under a prior plan which was then replaced by coverage under the Plan, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

The Claims Administrator is not the Plan Sponsor's designated "plan administrator" as that term is used in federal law, and the Claims Administrator does not assume any responsibilities of a "plan administrator" according to federal law.

The Claims Administrator is not obligated to provide continuation coverage to you if the Plan Sponsor or its Plan Administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Plan Sponsor or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying the Claims Administrator in a timely manner of your election of continuation coverage.

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

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

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

Qualifying Events for Continuation Coverage under COBRA

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

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
ASCEN WORKFORCE, LLC files for bankruptcy under Title 11, United States Code.	36 months	36 months	36 months

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

How Your Medicare Eligibility Affects Dependent COBRA Coverage

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

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

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

Notification Requirements

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

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

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

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

Notification Requirements for Disability Determination

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

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 11: *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

When COBRA Ends

COBRA coverage will end before the maximum continuation coverage period on the earliest of the following dates:

- The date, after electing continuation coverage, that coverage is first obtained under any other group health plan.
- The date, after electing continuation coverage, that you or your Enrolled Dependent first becomes entitled to Medicare.
- The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days).
- The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date).
- The date the entire Plan ends.
- The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

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

Section 4: Schedule of Benefits

Please Note: This Plan does not include benefits for services by out-of-Network providers except as specifically described in this Schedule of Benefits.

How Do You Access Benefits?

You must see a Network Physician, facility or other healthcare provider in order to obtain Benefits. Except as specifically described in this Schedule of Benefits, Benefits are not available for services provided by out-of-Network providers. This Benefit plan does not provide an out-of-Network level of Benefits.

Benefits apply to Covered Health Care Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Care Physician in order to obtain Benefits.

Covered Health Care Services provided at certain Network facilities by an out-of-Network facility-based Physician, will be reimbursed as set forth under Allowed Amounts as described at the end of this Schedule of Benefits. For these Covered Health Care Services, "certain Network facility" is limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act)*, an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

Medical transportation is not covered by the Plan.

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 this plan. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the Network of providers and how your Benefits may be affected appears at the end of this Schedule of Benefits.

If there is a conflict between this Schedule of Benefits and any summaries provided to you by the ASCEN WORKFORCE, LLC, this Schedule of Benefits will control.

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Benefits

Benefits for Covered Health Care Services are described below.

Out-of-Pocket Limits are calculated on a Calendar Year basis.

Benefit limits including Annual Visit Limits and Annual Days of Service Limits are calculated on a Calendar Year basis unless otherwise specifically stated.

Annual Deductible

This Plan has no Annual Deductible.

Out-of-Pocket Limit

The Out-of-Pocket Limit is the maximum you pay per Calendar Year for the Copayments and Coinsurance. Once you reach the Out-of-Pocket Limit, Benefits are payable at 100% of Allowed Amounts during the rest of that Calendar Year. The Out-of-Pocket Limit applies to Covered Health Care Services as indicated in this Schedule of Benefits, including Covered Health Care Services provided under Section 10: *Prescription Drug*.

Details about the way in which Allowed Amounts are determined appear at the end of the Schedule of Benefits table.

The Out-of-Pocket Limit does not include any of the following and, once the Out-of-Pocket Limit has been reached, you still will be required to pay the following:

- Any charges for non-Covered Health Care Services.
- Charges that exceed Allowed Amounts, when applicable.
- Charges that exceed any Annual Visit Limit or Annual Days of Service Limit.

Network Out-of-Pocket Limit	$9,200 per Covered Person, not to exceed $18,400 for all Covered Persons in a family.

The following table identifies what does and does not apply toward Out-of-Pocket Limits:

Plan Features	**Applies to the Network Out-of-Pocket Limit?**
Copays	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Care Services	No
Charges that exceed Allowed Amounts, when applicable	No
Charges that exceed any Annual Visit Limit or Annual Days of Service Limit.	No

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Care Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count towards the Out-of-Pocket Limit. If the Allowed Amount is less than the Copay, you are only responsible for paying the Allowed Amounts and not the Copay.

Coinsurance

Coinsurance is the percentage of Allowed Amounts that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Care Services. Coinsurance counts towards the Out-of-Pocket Limit.

Annual Visit Limits

Annual Visit Limit is the maximum number of visits that the Plan will cover for certain health care services during the year. Some Covered Health Care Services such as physician office services, alternative practitioner office services and urgent care services are subject to an annual visit limit. After an annual visit limit is reached, you will have to pay for any visits that exceed the annual visit limit.

Annual Days of Service Limits

Annual Days of Service Limit is the maximum number of days of outpatient testing that the Plan will cover during the year. Minor diagnostic tests, such as laboratory and urinalysis, are subject to separate annual days of service limits with no limit on the number of tests done per day. You will have to pay for any testing that is done after an Annual Days of Service Limit is reached for minor diagnostic testing.

Covered Health Care Service	Network	Out-of-Network**

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amounts in Section 12: *Defined Terms*. The Allowed Amounts provision near the end of the Schedule of Benefits, will tell you when you are responsible for amounts that exceed the Allowed Amount.

Clinical Trials

	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.	not covered

Diabetes Services

Outpatient Self-Management and Training; Eye Exams/Foot Care	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	not covered

Gender Dysphoria

	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.	not covered

Mental Health Care and Substance-Related and Addictive Disorders Services

	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	not covered

Minor Outpatient Diagnostic – Laboratory Tests

• Annual Days of Service Limit: one (1) dates for diagnostic lab tests per year, regardless of setting • Unlimited number of tests when provided on the same date of service • Technical and professional fees are covered	$50 Copayment per day of service at a Freestanding Diagnostic Center or in a Physician's office $150 Copayment per day of service at an Outpatient Hospital-Based Facility	not covered not covered

Pharmaceutical Products Administered on an Outpatient Basis

	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this Schedule of Benefits.	not covered

Covered Health Care Service	Network	Out-of-Network**

Amounts which you are required to pay as shown below in the Schedule of Benefits are based on Allowed Amounts or, for specific Covered Health Care Services as described, in the definition of Recognized Amounts in Section 12: *Defined Terms*. The Allowed Amounts provision near the end of the Schedule of Benefits, will tell you when you are responsible for amounts that exceed the Allowed Amount.

Physician's Office Visit

- Annual Visit Limit of up to four (4) combined In-person or online telemedicine visits per year including minor surgical procedures performed during office visit

Primary Care Physician	$25 Copayment/visit	not covered
Specialist Physician	$50 Copayment/visit	not covered

Pregnancy Services

	Depending upon where the Covered Health Care Service is provided, Benefits will be the same as those stated under each Covered Health Care Service category in this *Schedule of Benefits*.	not covered

Preventive Care Health Services

	$0 Copayment. Covered in full.	not covered

Urgent Care Center Services

• Annual Visit Limit of two (2) visits per year • Includes professional and facility charges only; • Radiology/X-ray, CT scans, PET scans, MRIs, MRA, nuclear medicine and any other diagnostic services are not covered.	$150 Copayment per visit	not covered

Virtual Care Services

Benefits are available only when services are delivered through Healthiest You. You can find a Provider by going to member.healthiestyou.com or by calling 1-866-703-1259.	$0 Copayment. Covered in full.	not covered

** Certain Health Care Services provided by out-of-Network providers will be covered as in-network as required under the *No Surprises Act of the Consolidated Appropriations Act* (P.L. 116-260). Allowed Amounts for these services will be determined as described below under Allowed Amounts.

Allowed Amount

Allowed Amounts are the amount the Claims Administrator determines that the Plan will pay for Benefits.

- For Network Benefits, for Covered Health Care Services provided by a Network provider, except for cost sharing obligations, you are not responsible for any difference between Allowed Amounts and the amount the provider bills.
- For Covered Health Care Services that are ***Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment, Coinsurance or deductible which is based on the Recognized Amount as defined in this SPD.
- For Covered Health Care Services that are ***non-Ancillary Services received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below***, you are not responsible, and the out-of-Network provider may not bill you, for amounts in excess of your Copayment or Coinsurance which is based on the Recognized Amount as defined in the SPD.

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

For Network Benefits, Allowed Amounts are based on either of the following:

- When Covered Health Care Services are received from a Network provider, Allowed Amounts are the Claims Administrator's contracted fee(s) with that provider.
- When covered health Care Services are received from an out-of-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 Care Services. Allowed Amounts 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 or Copayment. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

When Covered Health Care Services are received from an Out-of-Network provider as described below, Allowed Amounts are determined as follows:

For non-Emergency Covered Health Care Services received at certain Network facilities from out-of-Network Physicians when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service Act* with respect to a visit as defined by the Secretary (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the Allowed Amount is based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by state *All Payer Model Agreement*.
- The reimbursement rate as determined by applicable state law.
- The initial payment made by the Claims Administrator, or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
- The amount determined by *Independent Dispute Resolution (IDR)*.

For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act)*, a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act),* an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

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

IMPORTANT NOTICE: Out-of-Network providers may bill you for any difference between the provider's billed charges and the Allowed Amount described here.

Provider Network

The Claims Administrator or its affiliates arrange for health care providers to take part in a Network. Network providers are independent practitioners. They are not the Employer's or the Claims Administrator's employees. It is your responsibility to choose your provider.

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

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the telephone number on your ID card. A directory of providers is available by contacting the Claim Administrator's website or the telephone number on your ID card to request a copy.

If you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly prior to receipt of the Covered Health Care Service that the provider was a Network provider, either through a database, provider directory, or in response to your request for such information (via telephone, electronic, web-based or internet-based means), you may be eligible for cost sharing (Co-payment and Co-insurance) that would be no greater than if the service had been provided from a Network provider.

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 Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) 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. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

If you are currently undergoing a course of treatment utilizing an out-of-network Physician or health care facility, you may be eligible to receive Transition of Care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for Transition of Care Benefits, please contact the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Care Services. Some Network providers contract with the Claims Administrator to provide only certain Covered Health Care Services, but not all Covered Health Care Services. Some Network providers choose to be a Network provider for only some of the Claim Administrator's products. Refer to the provider online directory or contact the Claims Administrator for assistance.

Health Care Services from Out-of-Network Providers Paid as Network Benefits

If specific Covered Health Care Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Care Services are received from out-of-Network providers. In this situation, your Network Physician will notify the Claims Administrator and, if confirmed that care is not available from a Network provider, the Claims Administrator will work with you and your Network Physician to coordinate care through an out-of-Network provider.

Limitations on Selection of Providers

If the Claims Administrator determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, the Claims Administrator may require you to select a single Network Physician to provide and coordinate all future Covered Health Care Services.

If you don't make a selection within 31 days of the date the Claims Administrator notifies you, the Claims Administrator will select a single Network Physician for you.

If you do not use the selected Network Physician, Covered Health Care Services will be paid as Out-of-Network Benefits.

When Are Benefits Available for Prescription Drug Products?

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is placed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service. Refer to Section 10: *Prescription Drug* for further coverage and exclusion information.

Benefits for Preventive Care Medications are available as required under the Patient Protection and Affordable Care Act (PPACA).

What Happens When a Brand-name Drug Becomes Available as a Generic?

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change. Therefore your Copayment or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-Name Prescription Drug Product.

What Happens When a Biosimilar Becomes Available for a Reference Product?

If a biosimilar becomes available for a reference product (a biological Prescription Drug Product), the tier placement of the reference product may change. Therefore, your Co-payment and/or Co-insurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular reference product.

How Do Supply Limits Apply?

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the Benefit Information section. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that have been developed. Supply limits are subject from time to time to the Claims Administrator's review and change. This may limit the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may find out whether a Prescription Drug Product has a supply limit for dispensing by contacting the Claims Administrator at flexwork.uhc.com or the telephone number on your ID card.

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. The reason for obtaining prior authorization is to determine if the Prescription Drug Product is eligible for coverage. Medical Necessity goes beyond drug and diagnosis and takes into consideration the clinical appropriateness of a medication in terms of condition being treated, severity of conditions, type of medication, frequency of use, and duration of therapy. You may determine whether a Prescription Drug Product requires prior authorization by contacting the Claims Administrator at flexwork.uhc.com or the telephone number on your ID card.

Does Step Therapy Apply?

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Section are subject to step therapy requirements. In order to receive Benefits for such Prescription Drug Products you must use a different Prescription Drug Product(s) or Pharmaceutical Product(s) for which Benefits are provided as described under the Summary Plan Description first.

You may find out whether a Prescription Drug Product is subject to step therapy requirements by contacting the Claims Administrator at flexwork.uhc.com or the telephone number on your ID card.

What Do You Pay?

You are responsible for paying the applicable Copayment or Coinsurance. We may not permit certain coupons or offers from pharmaceutical manufacturers or an affiliate to apply to your Out-of-Pocket Limit.

Benefits for Preventive Care Medications are not subject to payment of the Copayments or Coinsurance.

The amount you pay for the following under Section 10: *Prescription Drug* will not be included in calculating any Out-of-Pocket Limit:

- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product. The Claims Administrator's contracted rates (the Claims Administrator's Prescription Drug Cost) will not be available to you.
- Certain coupons or offers from pharmaceutical manufacturers or an affiliate.
- Ancillary Charges

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. An Ancillary Charge does not apply to any Out-of-Pocket Limit.

Payment Information

Annual Deductible

This Plan has no Annual Deductible.

Copayment

Copayment for a Prescription Drug Product at a Network Pharmacy is a specific dollar amount.

Coinsurance

Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Cost.

Copayment and Coinsurance

Your Copayment and/or Coinsurance is determined by the Prescription Drug List (PDL) Management Committee's tier placement of a Prescription Drug Product.

Special Programs

The Claims Administrator may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication regimens. You may access information on these programs by contacting the Claims Administrator at flexwork.uhc.com or the telephone number on your ID card.

NOTE: The tier placement of a Prescription Drug Product can change from time to time. These changes generally happen twice a year, but no more than six times per Calendar Year, based on the PDL Management Committee's tiering decisions. When that happens, you may pay more or less for a Prescription Drug Product, depending on its tier placement. Please contact the Claims Administrator at flexwork.uhc.com or the telephone number on your ID card for the most up-to-date tier status.

For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:

- The applicable Copayment or Coinsurance.
- The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product.
- The Prescription Drug Cost for that Prescription Drug Product.

See the Copayments or Coinsurance stated in the Benefit Information table for amounts.

NOTE: Benefits for Preventive Care Medications are not subject to payment of Copayments or Coinsurance.

Benefit Information

Prescription Drugs from a Retail Network Pharmacy

The following supply limits apply:

- As written by the provider, up to a consecutive 30-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. Applicable copayments are applied per 30-day supply.
- When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 30-day supply, the Copayment or Coinsurance that applies will reflect the number of days dispensed.

Your Copayment or Coinsurance is determined by the tier to which the Prescription Drug List Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier-1, Tier-2, Tier-3, or Tier-4. Please contact the Claims Administrator at flexwork.uhc.com or the telephone number on your ID card to determine tier status.

For a Tier-1 Prescription Drug Product:
$15 Copayment

For a Tier-2 Prescription Drug Product:
$30 Copayment

For a Tier-3 Prescription Drug Product:
50% Coinsurance

For a Tier-4 Prescription Drug Product:
50% Coinsurance

Preventive Care Medications
$0 Copayment and 0% Coinsurance

Specialty Prescription Drug Products from a Preferred Specialty Network Pharmacy

This Plan does not cover Specialty Prescription Drugs.

Prescription Drug Products from a Mail Order Network Pharmacy

This Plan does not cover Mail Order Prescription Drugs.

Section 5: Covered Health Care Services

When Are Benefits Available for Covered Health Care Services?

Benefits are available only when all of the following are true:

- The health care service, including supplies or Pharmaceutical Products, is only a Covered Health Care Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Care Service in Section 12: *Defined Terms)*
- You receive Covered Health Care Services while the Plan is in effect.
- You receive Covered Health Care Services prior to the date that any of the individual termination conditions listed in Section 3*: When Coverage Ends* occurs.
- The person who receives Covered Health Care Services is a Covered Person and meets all eligibility rules specified in the Plan.

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 disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Care Service under the Plan.

Benefits are provided for 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 *Schedule of Benefits*.

Benefits are provided for nutritional counseling services provided by an appropriate licensed or registered health care professional for the treatment of medical or mental health conditions. Benefits for the services are provided under the applicable Benefit category in this section. Nutritional counseling services for preventive care are described under Preventive Care Services.

This section describes Covered Health Care Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Care Services (including any Copayment amounts).
- Any limit that applies to these Covered Health Care Services (including visit, day and dollar limits on services).
- Any limit that applies to the portion of the Allowed Amount or the Recognized Amount when applicable, you are required to pay in a year (Out-of-Pocket Limit).

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

Clinical Trials

Although the Plan does not include separate clinical trial benefits, Members can use other Covered Health Care benefits for clinical trial services, such as office visits for routine patient care incurred while taking part 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 which is likely to cause death unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, when the Claims Administrator determines, the clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, when the Claims Administrator determines, the clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening when the Claims Administrator determines, the clinical trial meets the qualifying clinical trial criteria stated below.

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

Benefits are available only when you are clinically eligible as determined by the researcher, to take part in the qualifying clinical trial.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Care Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Care Services required solely for the following:
    - The provision of the Experimental or Investigational Service(s) or item,
    - The clinically appropriate monitoring of the effects of the item or service, or
    - The prevention of complications.
- Covered Health Care Services needed for reasonable and necessary care arising from the receipt of an Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item.
- Items and services provided solely to meet data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that clearly does not meet 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 taking part 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. It takes place in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition. It meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease, 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. It takes place in relation to the detection or treatment of such non-life-threatening disease or disorder. It 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* if the study or investigation has been reviewed and approved through a system of peer review. The peer review system 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 takes place 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. It must have been approved by all relevant institutional review boards (IRBs) before you are enrolled in the trial. The Claims Administrator 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 Care Service and is not otherwise excluded under the Plan.

Diabetes Services

Outpatient Self-Management Training, Eye Exams and 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 healthcare professionals.

Benefits also include medical eye exams (dilated retinal exams) and preventive foot care for diabetes.

Gender Dysphoria

Although the Plan does not include separate gender dysphoria benefits, Members can use other Covered Health Care Benefits for the treatment of gender dysphoria provided by or under the direction of a Physician:

For the purpose of this Benefit "gender dysphoria" is a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the Mental Disorders published by American Psychiatric Association.

Mental Health Care and Substance Related and Addictive Disorder Services

Although the Plan does not include a separate Mental Health / Substance Use Disorder benefit, Members can:

- Use other Covered Health Care benefits for Mental Health / Substance Use Disorder services, such as using doctor office visits to see a behavioral specialist

Minor Outpatient Diagnostic: Laboratory

Services for Sickness and Injury-related diagnostic laboratory, received at a Hospital, Alternate Facility or in a Physician's office include, but are not limited to:

Benefits include:

- The physician and facility charge; and
- The charge for supplies and equipment.
- Genetic Testing ordered by a Physician which results in available medical treatment options following Genetic Counseling.
- Presumptive Drug Tests and Definitive Drug Tests.

Diagnostic laboratory services for preventive care are described under Preventive Care Services.

Pharmaceutical Products Administered on an Outpatient Basis

Pharmaceutical Products for Covered Health Care Services administered on an outpatient basis in a Physician’s office setting. Benefits are provided for Pharmaceutical Products which, due to their traits (as determined by the Claims Administrator), are 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 the Summary Plan Description. Benefits for medication normally available by a prescription order or refill are provided as described under your Outpatient Prescription Drug Benefit.

Physician's Office Visit

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Care Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals.

Covered Health Care Services include Genetic Counseling, allergy injections and surgical procedures performed in an office setting.

Covered Health Care Services for Preventive Care provided in a Physician's office are described under Preventive Care Services.

When a test is performed or a sample is drawn in the Physician's office, Benefits for the analysis or testing of a diagnostic laboratory, whether performed in or out of the Physician's office, are described under *Minor Outpatient Diagnostic: Laboratory*.

Pregnancy Services

Although the Plan does not include a separate maternity services and newborn well baby care benefits, Member can:

Use other Covered Health Care benefits for maternity services and newborn well baby care services, such as using doctor office visits for Covered Health Care Services incurred by you or your Enrolled Dependent Spouse or daughter for a normal Pregnancy.

The plan will provide these Benefits on the same basis as they pay for Benefits for a Sickness, according to:

- Guidelines established by the American College of Obstetricians and Gynecologists; or
- Any other established professional medical association.

IMPORTANT: To provide coverage for the child, (Including Newborn Well Baby Care), you must enroll the child under the plan as required under adding new dependents in Section 2: *When Coverage Begins* sub-section *When Do You Enroll and When Does Coverage Begin?*. Failure to enroll will result in no coverage for the newborn under this plan.

Preventive Care Health Services

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

- Evidence-based items or services that have an “A” or “B” rating in current recommendations of the United States preventive Services Task Force.
- Immunizations that have in effect a recommended by 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*.

Benefits defined under the *Health Resources and Services Administration* (HRSA) requirement include one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can find more information on how to access Benefits for breast pumps by contacting the Claims Administrator at flexwork.uhc.com or the telephone number on your ID card.

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

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented (and the duration of any rental).
- Timing of purchase or rental.

Urgent Care Center Services

Covered Health Care Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in Physician’s office, Benefits are available as described under Physician's Office Visit.

Radiology/X-ray, CT scans, PET scans, MRIs, MRAs, nuclear medicine or any other diagnostic service are not covered.

Virtual Care Services

Virtual care visits for Covered Health Care Services that include the diagnosis and treatment of less serious conditions. Virtual care provides communication of medical information in real-time between the patient and a distant Physician or health specialist outside of a medical facility (for example, from home or from work).

Benefits are available for urgent, on-demand health care delivered through live audio with video conferencing or audio only technology for treatment of acute but non-emergency needs.

Benefits are available only when services are delivered through HealthiestYou. You can access HealthiestYou by:

- Downloading the HealthiestYou app,
- visit the website at member.healthiestyou.com; or
- call 1-866-703-1259 to set up your account.

Please Note: Not all medical conditions can be treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is needed.

Benefits do not include email or fax, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Section 6: Exclusions and Limitations

How Are Headings Used in this Section?
To help you find exclusions, this section contains headings (for example Alternative Treatments below). The headings group services, treatments, items, or supplies that fall into a similar category. Exclusions appear under the headings. A heading does not create, define, change, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Does Not Pay Benefits for Exclusions
The Plan will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Care Services, except as may be specifically provided for in Section 5: *Covered Health Care Services* or through an Amendment to the Plan.

Where Are Benefit Limitations Shown?
When Benefits are limited within any of the Covered Health Care Services categories described in Section 5: *Covered Health Care Services*, those limits are stated in the corresponding Covered Health Care Service category in Section 4: *Schedule of Benefits*. Limits may also apply to some Covered Health Care Services that fall under more than one Covered Health Care Service category. When this occurs, those limits are also stated in Section 4: *Schedule of Benefits*. 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," it is not the intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

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

Cellular and Gene Therapy

- Administration of living whole cells into a patient for the treatment of disease.
- Therapeutic delivery of nucleic acid (DNA or RNA) into a patient's cells as a drug to treat a disease.

Chiropractic Treatment

Manipulative therapy and associated office visit, to restore normal function to the nerve system and body structures.

Dental

All dental services are excluded.

Devices, Appliances, Prosthetics and Supplies

This exclusion includes but is not limited to:

- Devices used as safety items or to help performance in sports–related activities.
- Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics, and some types of braces, including over the counter orthotic braces.
- The following items are excluded, even if prescribed by a Physician:
    - Blood pressure cuff/monitor.
    - Enuresis alarm.
    - Non-wearable external defibrillator.
    - Trusses.
    - Ultrasonic nebulizers.
- Devices and computers to help in communication and speech.
- Oral appliances for snoring.
- Repair or replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.
- Diagnostic or monitoring equipment purchased for home use, unless otherwise described as a Covered Health Care Service.
- Powered and non-powered exoskeleton devices.

Drugs

- Prescription drug products for outpatient use that are filled by a prescription order or refill.
- Self-administered or self-infused medications. This exclusion does not apply to medications which, due to their traits (as determined by the Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
- 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 used while in the Physician's office.
- Over-the-counter drugs and treatments.
- Certain new Pharmaceutical Products and/or new dosage forms until the date as determined by the Claims Administrator or 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 in Section 5: *Covered Health Care Services.*
- A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescribed drug product as described in Section 10: *Prescription Drug*. Such determinations may be made up to six times during a calendar year.
- A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescribed drug product as described in Section 10: *Prescription Drug*. Such determinations may be made up to six times during a calendar year.
- A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product or prescribed drug product as described in Section 10: *Prescription Drug*. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful

differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

- Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available to another Pharmaceutical Product or prescribed drug product as described in Section 10: *Prescription Drug*, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year.
- Certain Pharmaceutical Products that have not been prescribed by a Specialist.
- Compounded drugs that contain certain bulk chemicals. Compounded drugs that are available as a similar commercially available Pharmaceutical Product.

Durable Medical Equipment (DME), Orthotics and Supplies and Ostomy Supplies

DME and Supplies

Examples of DME and supplies include:

- Equipment to help mobility, such as a walker, cane, or standard wheelchair.
- A standard hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Mechanical equipment needed for the treatment of long term or sudden respiratory failure (except that air–conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related needed supplies as described under Diabetes Services.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this SPD.
- Lymphedema stockings for the arms.
- Dedicated speech generating devices and trachea esophageal voice devices.

Orthotics

Orthotic braces, including needed changes to shoes to fit braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are a Covered Health Care Service.

Ostomy supplies

- Pouches, face plates and belts;
- Irrigation sleeves, bags and catheters;
- Skin barriers; and
- Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, and adhesive remover.

Emergency Health Care Services

Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services received on an outpatient basis at a Hospital or Alternate Facility.

Include the facility charge, supplies and all professional services required to stabilize the condition and/or begin treatment. This includes placement in an observation bed to monitor your condition.

Experimental or Investigational Services or Unproven Services

Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational Services and Unproven Services are excluded. The fact that an Experimental or Investigational Service 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.

This exclusion does not apply to Covered Health Care Services provided during a clinical trial for which Benefits are provided as described under Clinical Trials in Section 5: *Covered Health Care Services*.

Foot Care

- Routine foot care. Examples include:
    - Cutting or removal of corns and calluses.
    - Nail trimming, cutting, or debridement.
    - Hygienic and preventive maintenance foot care including cleaning and soaking the feet and 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.
- Shoes.
- Shoe orthotics.
- Shoe inserts.
- Arch supports.

Gender Dysphoria

Cosmetic Procedures, including the following:

- Abdominoplasty.
- Blepharoplasty.
- Body contouring, such as lipoplasty.
- Brow lift.
- Calf implants.
- Cheek, chin, and nose implants.
- Injection of fillers or neurotoxins.
- Face lift, forehead lift, or neck tightening.
- Facial bone remodeling for facial feminizations.
- Hair removal.
- Hair transplantation.
- Lip augmentation.
- Lip reduction.
- Liposuction.
- Mastopexy.
- Pectoral implants for chest masculinization.
- Rhinoplasty.
- Skin resurfacing.

Hearing Aid

An electronic amplifying device designed to bring sound more effectively into the ear. A Hearing Aid consists of microphone, amplifier and receiver.

Home Health Care

Services received from a Home Health Agency that include the following:

- Provided in your home by a registered nurse, therapist, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.
- Provided on a part-time Intermittent Care schedule.
- Provided when skilled care is required.

Hospice Care

Hospice care is an integrated program that provides comfort and support services for the terminally ill. It includes the following:

- Physical, psychological, social and spiritual care for the Terminally ill person.
- Short-term grief counseling for immediate family members while you are receiving hospice care.

Hospital – Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital.

- Supplies and non-Physician services received during the Inpatient Stay;
- Room and board in a Semi-Private Room; and
- Services provided by a Physician for the diagnosis and treatment of a Sickness or Injury received during the Inpatient Stay.

Major and Minor Diagnostic Imaging Tests

Services for Sickness and Injury-related to major and minor diagnostic imaging tests, received in a Physician's office, Hospital or Alternate Facility, including charges for physician, facility, supplies and equipment. Examples include:

Services for X-rays, EKGs, ultrasounds, CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services.

Medical Supplies and Equipment

- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
    - Compression stockings.
    - Ace bandages.
    - Gauze and dressings.

Medical Transportation, including Emergency Medical Transportation

- Emergency ambulance transportation by a licensed ambulance service (either ground or Air Ambulance) to the nearest Hospital where the required Emergency Health Care Services can be performed.
- Non-Emergency ambulance transportation by a licensed ambulance service, either ground or Air Ambulance.

Nutrition

- Nutritional counseling that is non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the United States Preventive Services Task Force requirement.
- Food of any kind, infant formula, standard milk-based formula, and donor breast milk.
- Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition–based therapy. Examples include supplements and electrolytes.

Outpatient Therapeutic Treatments

- Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Dialysis, both hemodialysis and peritoneal dialysis,
- Intravenous chemotherapy or other intravenous infusion therapy,
- Radiation oncology.

Personal Care, Comfort or Convenience

- Television.
- Telephone.
- Beauty/barber service.
- Guest service.
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners, air purifiers and filters, dehumidifiers.
  - Batteries and battery chargers.
  - Car seats.
  - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts, and recliners.
  - Exercise equipment.
  - Home modifications such as elevators, handrails and ramps.
  - Hot and cold compresses.
  - Hot tubs.
  - Humidifiers.
  - Jacuzzis.
  - Mattresses.
  - Medical alert systems.
  - Motorized beds.
  - 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

- Cosmetic Procedures. See the definition in Section 12: *Defined Terms*. Examples include:
  - Pharmacological regimens, nutritional procedures or treatments.
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures.
  - Skin abrasion procedures performed as a treatment for acne.
  - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
  - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
  - Treatment for spider veins.
  - Sclerotherapy treatment of veins.
  - Hair removal or replacement by any means.
- Breast implants or replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).

- Physical conditioning programs such as athletic training, body-building, exercise, fitness, or flexibility.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
- Wigs regardless of the reason for the hair loss

Physician Fees for Surgical Services

- Physician fees for surgical procedures received on an outpatient or inpatient basis in a Hospital or Alternate Facility.
- Anesthesia services.

This exclusion does not apply to outpatient surgery done in an Urgent Care Center or Physician's Office.

Procedures and Treatments

- Removal of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty, and brachioplasty.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
- Rehabilitation services and Manipulative Treatment to improve general physical conditions that are provided to reduce potential risk factors, where improvement is not expected, including routine, long-term or maintenance/preventive treatment.
- Physiological treatments and procedures that result in the same therapeutic effects when performed on the same body region during the same visit or office encounter.
- Biofeedback.
- Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), whether the services are considered to be medical or dental in nature.
- Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment.
- Surgical and non-surgical treatment of obesity.
- Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in tobacco cessation and may include a psychologist, social worker or other licensed or certified professionals. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
- Breast reduction surgery that is determined to be a Cosmetic Procedure.
- Helicobacter pylori (H. pylori) serologic testing.
- Intracellular micronutrient testing.

Providers

- Services performed by a provider who is a family member by birth or marriage. Examples include a Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal address.
- Services provided at a Free-standing Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Free-standing Facility or diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Free-standing Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
    - Has not been actively involved in your medical care prior to ordering the service, or
    - Is not actively involved in your medical care after the service is received.

  This exclusion does not apply to mammography.
- Services performed by an Out-of-Network provider, except as specifically described in Section 4: *Schedule of Benefits.*

Reconstructive Procedures

- Surgery or other procedures which are related to an Injury, Sickness or Congenital Anomaly.
- The primary result of the procedure is not a changed or improved physical appearance.

Rehabilitation and Habilitative Services - Outpatient Therapy

- Physical therapy;
- Occupational therapy;
- Speech therapy;
- Pulmonary rehabilitation therapy;
- Cardiac rehabilitation therapy; and
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy

Reproduction

- Services incurred for a normal Pregnancy and childbirth. (This exclusion does not apply to maternity and childbirth services for which Benefits are provided as described in Section 5: Additional Coverage Details).
- Health Care Services and related expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.
- The following services related to Gestational Carrier or Surrogate:
    - All costs related to reproductive techniques including:
        - Assistive reproductive technology.
        - Artificial insemination.
        - Intrauterine insemination.
        - Obtaining and transferring embryo(s).
        - Preimplantation Genetic Testing (PGT) and related services.
    - Health care services including:
        - Inpatient or outpatient prenatal care and/or preventive care.
        - Screenings and/or diagnostic testing.
        - Delivery and post-natal care.

      (This exclusion for the health care services listed above does not apply when the Gestational Carrier or Surrogate is a Covered Person.)
    - All fees including:
        - Screening, hiring and compensation of a Gestational Carrier or Surrogate including surrogacy agency fees.
        - Surrogate insurance premiums.
        - Travel or transportation fees.
- Cost of donor eggs and donor sperm.
- Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
- The reversal of voluntary sterilization.
- Health Care Services and related expenses for non-surgical, or drug-induced Pregnancy termination. This exclusion does not apply to:
    - Treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage).
    - Is Necessary to avert substantial and irreversible impairment of a major bodily function.
    - A fetus that has a defect that is documented by a physician or physicians to be uniformly diagnosable and uniformly lethal, or

    - When the Pregnancy is the result of rape or incest.
- Elective fertility preservation.
- In vitro fertilization regardless of the reason for treatment.

Services Provided under another Plan

- Health Care Services for when other coverage is required by federal, state or local law to be bought or provided through other arrangements. Examples include coverage required by workers' compensation or similar legislation.
- If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
- 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.
- Health Care Services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health Care Services during active military duty.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility, including the following:

- Supplies and non-Physician services received during the Inpatient Stay; and
- Room and board in a Semi-Private Room
- Physician services for radiologists, anesthesiologists, and pathologists.

Surgery

- Surgery and related services received on an inpatient or outpatient basis at a Hospital or Alternate Facility. Benefits include certain scopic procedures. Examples of surgical scopic procedures include:
    - Arthroscopy,
    - Laparoscopy,
    - Bronchoscopy,
    - Hysteroscopy.
- Includes the facility charge and the charge for supplies and equipment.

This exclusion does not apply to outpatient surgery done in an Urgent Care Center or Physician’s Office.

Transplants

- Health Care Services for organ and tissue transplants.
- Health Care Services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Plan.
- Health Care Services for transplants involving animal organs.

Travel

- Health Care Services provided in a foreign country.
- Travel or transportation expenses, even though prescribed by a Physician.

Types of Care, Supportive Services and Housing

- Multi–disciplinary pain management programs provided on an inpatient basis for sharp, sudden pain or for worsened long term pain.
- Custodial Care or maintenance care.

- Domiciliary care.
- Private duty nursing.
- Respite care.
- Rest cures.
- Services of personal care aides.
- Independent living services.
- Assisted living services.
- Educational counseling, testing, and support services including tutoring, mentoring, tuition, and school-based services for children and adolescents required to be provided by or paid for by the school under the *Individuals with Disabilities Education Act*.
- Vocational counseling, testing, and support services including job training, placement services, and work hardening programs (programs designed to return a person to work or to prepare a person for specific work).
- Transitional Living services (including recovery residences).

Vision

- Cost and fitting charge for eye glasses and contact lenses.
- Routine vision exams, including refractive exams to determine the need for vision correction.
- Implantable lenses used only to fix a refractive error (such as Intacs corneal implants).
- Eye exercise therapy or vision therapy.
- Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser, and other refractive eye surgery.

All Other Exclusions

- Health Care Services and supplies that do not meet the definition of a Covered Health Care Service - Covered Health Care Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determine to be all of the following:
    - 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.
    - Described as a Covered Health Care Service in this Summary Plan Description under Section 5: *Additional Coverage Details* and in the Schedule of Benefits.
    - Not otherwise excluded in this Summary Plan Description under Section 6: *Exclusions and Limitations.*
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
    - Required only for career, school, sports or camp, travel, employment, insurance, marriage or adoption.
    - Related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
    - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Care Services provided during a clinical trial that meets the definition of a Phase I, II or III clinical trial described in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight. Benefits are provided as described under Section 5: Additional Coverage Details.
    - Required to obtain or maintain a license of any type.
- Health Care Services related to a non-Covered Health Care Service: When a service is not a Covered Health Care Service, all services related to that non-Covered Health Care Service are also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Care Services if they are to treat complications that arise from the non-Covered Health Care 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.

- Health Care Services received after the date your coverage under the Plan ends. This applies to all Health Care Services, even if the Health Care Service is required to treat a medical condition that arose before the date your coverage under the Plan ended.
- Health Care Services received due to war or any act of war, whether declared or undeclared or caused during service in the armed forces 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 non-war zones.
- Health Care Services for which you have no legal responsibility to pay, or when a charge would not ordinarily be made in the absence of coverage under the Plan.
- In the event an out-of-Network provider waives, does not pursue, or fails to collect Copayments or Coinsurance, or other amount owed for a particular Health Care Service, no Benefits are provided for the Health Care Service for which the Copayments or Coinsurance are waived.
- Charges in excess of Allowed Amounts, when applicable, or in excess of any specified limitation.
- Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
- Autopsy.
- Foreign Language and sign language interpretation services offered by or required to be provided by a Network or out-of-Network provider.

Section 7: How to File a Claim

Claims Mailing Address

FlexWork
P.O. Box 31375
Salt Lake City, UT 84131-0375

How Are Covered Health Care Services from Network Providers Paid?

The Claims Administrator processes payment to Network providers directly for your Covered Health Care Services. If a Network provider bills you for any Covered Health Care Service, contact the Claims Administrator. However, you are required to pay any required Copayments and Coinsurance to a Network provider.

How Are Covered Health Care Services from an Out-of-Network Provider Paid?

When you receive Covered Health Care Services from an out-of-Network provider, you are responsible for requesting payment from the Claims Administrator. You must file the claim in a format that contains all of the information the Claims Administrator requires, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to the Claims Administrator within one year of the date of service, Benefits for that health service will be denied or reduced, as the Claims Administrator determines. This time limit does not apply if you are legally incapacitated.

Required Information

When you request payment of Benefits from the Claims Administrator, you must provide the Claims Administrator with all of the following information:

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

The above information should be filed with the Claims Administrator at the address on your ID card.

When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx
PO Box 650334
Dallas, TX 75265-0334

Payment of Benefits

Any Allowed Amounts due to a provider may be paid directly to the provider instead of being paid to you. The Plan will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260) are paid directly to the provider.

You may not assign your Benefits under the Plan or any cause of action related to your Benefits under the Plan to an out-of-Network provider. The Plan may pay an out-of-Network provider directly for services rendered to you. In the case of such payment to an out-of-Network provider.

Any such payment to an out-of-Network provider:

- Is not an assignment of your Benefits under the Plan or of any legal or equitable right to institute any proceeding relating to your Benefits,
- Is not a waiver of the prohibition on assignment of Benefits under the Plans, and
- Will not preclude the Plan from asserting that any purported assignment of Benefits under the Plan is invalid and prohibited.

Allowed Amounts due to an out-of-Network provider for Covered Health Care Services that are subject to the No Surprises Act of the Consolidated Appropriations Act (P.L. 116-260) are paid directly to the provider.

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

Section 8: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What if You Have a Question?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

What if You Have a Complaint?

Call the telephone number shown on your ID card. Representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to the Plan in writing, the representative can provide you with the address.

If the representative cannot resolve the issue over the phone, he/she can help you prepare and submit a written complaint. The Plan will notify you of their decision regarding your complaint within 60 days of receiving it.

How Do You Appeal a Claim Decision?

Post-service Claims

Post-service claims are claims filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are requests that require prior notification or benefit confirmation prior to receiving medical care.

How to Request an Appeal

If you disagree with a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact the Plan in writing to request an appeal.

For non-urgent appeals, you may contact the Plan at:

Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Fax: 866-748-7820
Phone: 855-892-2401

If you feel your situation is urgent, you may request an expedited (urgent) appeal orally, by fax or in writing at:

Grievance Administrator
2020 Innovation Court
De Pere, WI 54115
Fax: 866-748-7304
Phone: 855-892-2401

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Plan within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will review the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with expertise in the field, who was not involved in the prior determination. The Claims Administrator may consult with, or ask medical experts to take part in the appeal process. You consent to this referral and the sharing of needed medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information related to your claim for Benefits. Any new or additional evidence relied upon or generated by the Plan during the determination of the appeal, will be provided to you free of charge and in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

For procedures related to urgent requests for Benefits, see Urgent Appeals that Require Immediate Action below.

You will be provided written or electronic notification of the decision on your appeal as follows:

For appeals of pre-service requests, for Benefits you will be notified of the decision within 15 days from receipt of a request for a first level appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. You will be notified of the decision within 15 days from receipt of a request for review of the second level appeal decision.

For appeals of post-service claims, you will be notified of the decision within 30 days from receipt of a request for a first level appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. This request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision. You will be notified of the decision within 30 days from receipt of a request for review of the second level appeal decision.

Please note that the Plan's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure.

You may have the right to external review through an Independent Review Organization (IRO) upon the completion of the internal appeal process. Instructions regarding any such rights, and how to access those rights, will be provided in the Plan's decision letter to you.

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.

In these urgent situations:

The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible.

The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

If the Claims Administrator needs more information from your Physician to make a decision, the Claims Administrator will notify you of the decision by the end of the next business day following receipt of the required information.

The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

Federal External Review Program

You may be entitled to request an external review of the Claims Administrator's determination after exhausting your internal appeals if either of the following apply:

- You are not satisfied with the determination made by the Claims Administrator
- The Claims Administrator fails to respond to your appeal within the timeframe required by the applicable regulations.

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

- Clinical reasons.
- The exclusions for Experimental or Investigational Services or Unproven Services.
- Rescission of coverage (coverage that was cancelled or discontinued retroactively).
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address listed in the determination letter. You or your representative may request an expedited external review, in urgent situations as defined below, by contacting the telephone number on your ID card or by sending a written request to the address listed in the determination letter. A request must be made within four months after the date you received the Claims Administrator's final appeal decision.

An external review request should include all of the following:

- A specific request for an external review.
- Your name, address, and insurance ID number.
- Your designated representative's name and address, when applicable.
- The service that was denied.
- Any new, relevant information that was not provided during the internal appeal.

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

- A standard external review.
- An expedited external review.

Standard External Review

A standard external review includes all of the following:

- A preliminary review by the Claims Administrator of the request.
- A referral of the request by the Claims Administrator to the IRO.
- A decision by the IRO.

After receipt of the request, the Claims Administrator will complete a preliminary review within the applicable timeframe, to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has exhausted the applicable internal appeals process.

- Has provided all the information and forms required so that the Claims Administrator may process the request.

After the Claims Administrator completes this review, the Claims Administrator will issue a notification in writing to you. If the request is eligible for external review, the Claims Administrator will assign as IRO to conduct such review. The Claims Administrator will assign requests by either rotating among the IROs or by using a random selection process.

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

The Claims Administrator will provide to the assigned IRO the documents and information considered in making the Claims Administrator's determination.

The documents include:

- All relevant medical records.
- All other documents relied upon by the Claims Administrator.
- All other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request. The Claims Administrator will include it with the documents forwarded to the IRO.

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

If the Claims Administrator receives a Final External Review Decision reversing the Claims Administrator's determination, coverage or payment for the Benefit claim at issue will be provided according to the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision agrees with the Claims Administrator's determination, Benefits for the health care service or procedure will not be provided.

Expedited External Review

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

You may make a written or verbal request for an expedited external review, separately or at the same time you have filed a request for an expedited internal appeal, if you receive either of the following:

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

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

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

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

In reaching a decision, the IRO will review the claim as new and not be bound by any decisions or conclusions reached by the Claims Administrator. The IRO will provide notice of the final external review decision for an expedited external review as quickly as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the IRO's final external review decision is first communicated verbally, the IRO will follow-up with a written confirmation of the decision within 48 hours of that verbal communication.

You may call the telephone number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

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

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

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

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

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Claims Administrator must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, Claims Administrator must notify you within:	30 days
You must then provide completed claim information to Claims Administrator within:	45 days
Claims Administrator must notify you of the benefit determination:	
if the initial claim is complete, within:	30 days
after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
The Claims Administrator must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
Claims Administrator must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Section 9: GENERAL LEGAL PROVISIONS

What is Your Relationship with the Claims Administrator and ASCEN WORKFORCE, LLC?

It is important for you to understand the Claims Administrator's role with respect to the Plan and how it may affect you. The Claims Administrator helps administer the Plan Sponsor's benefit plan in which you are enrolled. The Claims Administrator and the Plan Sponsor do not provide medical services or make treatment decisions. This means:

- The Claims Administrator communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive. The Plan pays for Covered Health Care Services, which are more fully described in this SPD.
- The Plan may not pay for all treatments you or your Physician may believe are needed. If the Plan does not pay, you will be responsible for the cost.

ASCEN WORKFORCE, LLC and the Claims Administrator may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. ASCEN WORKFORCE, LLC and the Claims Administrator will use individually identifiable information about you as permitted or required by law, including in operations and in research. ASCEN WORKFORCE, LLC and the Claims Administrator will use de-identified data for commercial purposes including research.

What is the Claims Administrator's Relationship with Providers and Plan Sponsors?

The Claims Administrator has agreements in place that govern the relationships between it and ASCEN WORKFORCE, LLC and Network providers, some of which are affiliated providers. Network providers enter into agreements with the Claims Administrator to provide Covered Health Care Services to Covered Persons.

ASCEN WORKFORCE, LLC and the Claims Administrator do not provide health care services or supplies, or practice medicine. ASCEN WORKFORCE, LLC and the Claims Administrator arrange for health care providers to participate in a Network and the Claims Administrator processes the Plan's payment of Benefits. Network providers are independent practitioners who run their own offices and facilities. The Claims Administrator's or its affiliates credentialing process confirms public information about the providers' licenses and other credentials. It does not assure the quality of the services provided. Network providers are not ASCEN WORKFORCE, LLC's employees. Network providers are not the Claims Administrator's employees. ASCEN WORKFORCE, LLC and the Claims Administrator are not responsible for any act or omission of any provider.

The Claims Administrator is not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Plan Sponsor's Plan. The Claims Administrator is not responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

ASCEN WORKFORCE, LLC is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Plan's Service Fee and premium to the Claims Administrator.
- The funding of Benefits on a timely basis.
- Notifying you of when the Plan ends.

When the Plan Sponsor establishes the Plan to provide coverage under a benefit plan governed by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 et seq., the Claims Administrator is not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U.S. Department of Labor.*

What is Your Relationship with Providers and Plan Sponsors?

The relationship between you and any provider is that of provider and patient.

You are responsible for all of the following:

- Choosing your own provider;

- Paying, directly to your provider, any amount identified as a participant responsibility, including Copayments, Coinsurance and any amount that exceeds Allowed Amounts, when applicable.
- Paying, directly to your provider, the cost of any non–Covered Health Care Service.
- Paying, directly to your provider, any amount that exceeds any Annual Visit Limit or Annual Days of Service Limit.
- Deciding if any provider treating you is right for you. This includes Network providers you choose and providers that they refer.
- Deciding with your provider what care you should receive.

Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and ASCEN WORKFORCE, LLC is that of employer and employee. Dependent or other classification as defined in the SPD.

Notice

When the Claims Administrator provides written notice regarding administration of the Plan to an authorized representative of the Plan Sponsor, that notice is deemed notice to all affected Participants and their Enrolled Dependents. The Plan Sponsor is responsible for giving notice to you.

Statements by the Plan Sponsor or Participants

All statements made by the Plan Sponsor or by a Participant shall, in the absence of fraud, be deemed representations and not warranties. The Claims Administrator will not use any statement made by the Plan Sponsor to void the Plan after it has been in force for two years unless it is a fraudulent statement.

Does the Claims Administrator Pay Incentives to Providers?

The Claims Administrator pays Network providers through various types of contractual arrangements. Some of these arrangements may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
- Capitation - A group of Network providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Network provider within the group to perform or coordinate certain health care services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- Bundled payments - certain Network providers receive a bundled payment for a group of Covered Health Care Services for a particular procedure or medical condition. The applicable Copayment and/or Coinsurance will be calculated based on the provider type that received the bundled payment. The Network providers receive these bundled payments regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment. If you receive follow-up services related to a procedure where a bundled payment is made, an additional Copayment and/or Coinsurance may not be required if such follow-up services are included in the bundled payment. You may receive some Covered Health Care Services that are not considered part of the inclusive bundled payment and those Covered Health Care Services would be subject to the applicable Copayment and/or Coinsurance as described in your *Schedule of Benefits*.

The Claims Administrator uses various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have any questions about whether your Network provider’s contract with the Claims Administrator includes any financial incentives, the Claims Administrator encourages you to discuss those questions with your provider. You may also call the Claims Administrator at the telephone number on your ID card. The Claims Administrator can advise whether your Network provider is paid by any financial incentive, including those listed above

Are Incentives Available to You?

Sometimes the Claims Administrator may offer coupons, enhanced Benefits, or other incentives to encourage you to take part in various programs, including 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 take part in a program is yours alone. However, you should discuss taking part in such programs with your Physician. Contact the Claims Administrator at the number on the back of your ID card if you have any questions.

Does the Claims Administrator Receive Rebates and Other Payments?

ASCEN WORKFORCE, LLC and the Claims Administrator may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. ASCEN WORKFORCE, LLC and the Claims Administrator may pass a portion or all of these rebates on to you. When rebates are passed on to you they may be taken into account in determining your Copayment and/or Coinsurance.

Who Interprets Benefits and Other Provisions under the Plan?

ASCEN WORKFORCE, LLC and the Claims Administrator have the sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions set out in the Plan, including this *SPD,* the *Schedule of Benefits* and any Addendums, Riders and/or Amendments.
- Make factual determinations related to the Plan and its Benefits.

ASCEN WORKFORCE, LLC and the Claims Administrator may assign this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Who Provides Administrative Services?

The Claims Administrator provides claims administrative services or, as the Claims Administrator determines, the Claims Administrator may arrange for various persons or entities to provide claims administrative services, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time as the Claims Administrator determines. The Claims Administrator is not required to give you prior notice of any such change, nor is the Claims Administrator required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

What is the Future of the Plan?

Although ASCEN WORKFORCE, LLC 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.

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

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

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

Amendments to the Plan

To the extent permitted by law, the Claims Administrator has the right, as it determines and without your approval, to change, interpret, withdraw or add Benefits or end the Plan.

Any provision of the Plan which, on its effective date, is in conflict with the requirements of applicable state law provisions not otherwise preempted by ERISA or federal statutes or regulations (of the jurisdiction in which the Plan is delivered) is amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Plan unless it is made by an Amendment. All of the following conditions apply:

- Amendments to the Plan are effective upon the Plan's next anniversary date, except as otherwise permitted by law.
- No agent has the authority to change the Plan or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Plan.

How Does the Claims Administrator Use Information and Records?

The Claims Administrator may use your individually identifiable health information as follows:

- To administer the Plan and pay claims.
- To identify procedures, products, or services that you may find valuable.
- As otherwise permitted or required by law.

The Claims Administrator may request additional information from you to decide your claim for Benefits. The Claims Administrator will keep this information confidential. The Claims Administrator may also use de-identified data for commercial purposes, including research, as permitted by law.

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

The Claims Administrator has the right to release records concerning health care services when any of the following apply:

- Needed to put in place and administer the terms of the Plan.
- Needed for medical review or quality assessment.
- Required by law or regulation.

During and after the term of the Plan, the Claims Administrator and the Claims Administrator's related entities may use and transfer the information gathered under the Plan in a de–identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements you may 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 Claims Administrator, the Claims Administrator also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, the Claims Administrator will designate other persons or entities to request records or information from or related to you, and to release those records as needed. The Claims Administrator's designees have the same rights to this information as the Claims Administrator has.

Does the Plan Require Examination of Covered Persons?

In the event of a question or dispute regarding your right to Benefits, the Plan Sponsor may require that a Network Physician of its choice examine you at the Plan's expense.

Is 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.

Subrogation and Reimbursement

The Plan has the 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 shall apply 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.
- Your employer in a workers’ compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity against whom you may have any claim for professional and/or legal malpractice arising out of or connected to 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 the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
    - Notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts 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 the Plan's 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 the Plan's agents' consent before releasing any party from liability or payment of medical expenses.

- Complying with the terms of this section.

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

- The Plan has a first priority right to receive payment on any claim against 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, your estate, your heirs and beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium 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.

- By participating in and accepting Benefits under the Plan, you agree that (i) any amounts recovered by you from any third party shall constitute Plan assets (to the extent of the amount of Benefits provided on behalf of the Covered Person), (ii) you and your representative shall be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts, and (iii) you shall be liable for and agree to pay any costs and fees (including reasonable attorney fees) incurred by the Plan to enforce its reimbursement rights.

- The Plan's right 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 Plan - 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 the Plan's rights under these provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits you receive for the 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 the Plan's 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 the Plan's 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 brings 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 any third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under the Plan, the provisions of this section continue to apply, even after you are no longer covered.

- In the event that you do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate Benefits to you, your dependents or the participant, 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 your failure to abide by the terms of 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 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 the Plan’s 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.

When Does the Plan Receive Refunds of Overpayments?

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

- All or some of the expenses were not paid or did not legally have to be paid by you.
- 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 refund equals the amount the Plan paid in excess of the amount the Plan should have paid under the Plan. If the refund is due from another person or organization, you agree to help the Plan get the refund when requested.
If the refund is due from you and you do not promptly refund the full amount, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, your future Benefits 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 payable 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 reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

Is There a Limitation of Action?

You cannot bring any legal action against the Plan or the Claims Administrator to recover reimbursement until you have completed all the steps in the appeal process described in Section 8: *Questions, Complaints and Appeals*. After completing that 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 the Plan notified you of its final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator.

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 Claims 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.

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

Plan Document

This Summary Plan Description (SPD) is the official plan document that has been adopted by the Company. There is no other document that controls the benefits under the Plan.

Section 10: Prescription Drug

Introduction Outpatient Prescription Drug Plan

Coverage Policies and Guidelines

The Claims Administrator's Prescription Drug List (PDL) Management Committee makes tier placement changes on the Claims Administrator's behalf. The PDL Management Committee places FDA-approved Prescription Drug Products into tiers by considering a number of factors including clinical and economic factors. Clinical factors may include, review of the place in therapy, or use as compared to other similar product or services, site of care, relative safety or effectiveness of the Prescription Drug Product, as well as if certain supply limits or prior authorization requirements should apply. Economic factors may include the Prescription Drug Product's total cost including any rebates and evaluations on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for treating specific conditions as compared to others; therefore, a Prescription Drug Product may be placed on multiple tiers according to the condition for which the Prescription Drug Product was prescribed to treat or according to whether it was prescribed by a Specialist.

The Claims Administrator may from time to time change the placement of a Prescription Drug Product among the tiers. These changes generally will happen quarterly, but no more than six times per Calendar Year. These changes may happen 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 you is a determination that is made by you and your prescribing Physician.

Note: The tier placement of a Prescription Drug Product may change from time to time 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 contact the Claims Administrator at flexwork.uhc.com or the telephone number on your ID card for the most up-to-date tier placement.

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 the Claims Administrator during regular business hours.

If you do not show your ID card or provide verifiable information at a Network Pharmacy, you must pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from the Claims Administrator as described in Section 7: *How to file a Claim*. When you submit a claim on this basis you may pay more if you did not verify your eligibility when the Prescription Drug Product was dispensed or when you utilize an out-of-network pharmacy. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance and Ancillary Charge that applies.

Submit your claim to:

Optum Rx
PO Box 650334
Dallas, TX 75265-0334

When Does the Claims Administrator Limit Selection of Pharmacies?

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

Rebates and Other Payments

The Claims Administrator may receive rebates for certain drugs included on the Prescription Drug List.

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

Coupons, Incentives and Other Communications

At various times, the Claims Administrator 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, as you determine, 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.

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at a Network Pharmacy and are subject to Copayments, or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the Section 4: *Schedule of Benefits* for applicable Copayments or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Care Service.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to Section 4: *Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Exclusions

Exclusions from coverage listed in the Summary Plan Description apply also to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can contact the Claims Administrator at flexwork.uhc.com or the telephone number on your ID card for information on which Prescription Drug Products are excluded.

- Prescription Drug Products obtained from an out-of-Network Pharmacy.
- Coverage for Prescription Drug Products obtained from a mail order pharmacy.
- Specialty Prescription Drug Product: Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
- Prescription Drug Products dispensed outside the United States.
- Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.

- Experimental or Investigational Services or Unproven Services and medications; medications used for experimental treatments for specific disease and/or dosage regimens determined by the Claims Administrator to be experimental, investigational or unproven.

- Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent 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.

- Prescription Drug Products 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.

- Any product dispensed for the purpose of appetite suppression or weight loss.

- A Pharmaceutical Product for which Benefits are provided in your Summary Plan Description.

- Durable Medical Equipment, including certain insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your Summary Plan Description. Prescribed and non-prescribed outpatient supplies. This does not apply to diabetic supplies and inhaler spacers specifically stated as covered.

- General vitamins, except the following which require a Prescription Order or Refill:

    - Prenatal vitamins
    - Vitamins with fluoride
    - Single entity vitamins

- Certain Prescription Drug Products that are repackaged, relabeled, or packaged as (a) unit dose(s).

- Prescription Drug Products used for cosmetic or convenience purposes.

- Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that the Claims Administrator determines do not meet the definition of a Covered Health Care Service.

- Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.

- Prescription Drug Products when prescribed to treat infertility.

- Certain prescription Drug Products for tobacco cessation that exceeds the minimum number of drugs required to be covered under the Patient Protection and Affordable Care Act (PPACA) in order to comply with essential health benefit requirements.

- Diagnostic kits and products, including associated services.

- Dental products, including but not limited to prescription fluoride topicals.

- Prescription Drug Products not placed on Tier-1, Tier-2, Tier-3, or Tier-4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed.

- The following over-the-counter drugs and products:

    - Drugs or products available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter drug or product as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician.

    - Over-the-counter continuous glucose monitors; and

    The following Prescription Drug Products with over-the-counter alternatives.

    - Prescription Drug Products that are available in over-the-counter form or made up of components that are available in over-the-counter form or equivalent. Such determinations may be made up to six times during a calendar year.

    - Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year.

The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

- 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 Management Committee.

- Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).

- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

- 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.

- A Prescription Drug Product that contains marijuana, including medical marijuana.

- A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the Summary Plan Description. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

- A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the Summary Plan Description. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

- Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives to another Prescription Drug Product or Pharmaceutical Product as described in the Summary Plan Description available, unless otherwise required by law or approved by the Claims Administrator. Such determinations may be made up to six times during a calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

- Certain Prescription Drug Products that have not been prescribed by a Specialist.

- Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under the Patient Protection and Affordable Care Act (PPACA) essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.

- A Prescription Drug Product with either:

  An approved biosimilar

  A biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product or Pharmaceutical Product as described in the Summary Plan Description

  For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on both of the following:

  It is highly similar to a reference product (a biological Prescription Drug Product)

  It has no clinically meaningful differences in terms of safety and effectiveness from the reference product

  Such determinations may be made up to six times per calendar year. The Claims Administrator may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision;

- Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

- 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.

- Prescription Drug Products prescribed by a provider who is on our list of excluded providers due to fraud, waste, and/or abuse findings.

Outpatient Prescription Drug Defined Terms

Ancillary Charge - a charge, in addition to the Deductible, Copayment and/or Coinsurance, that you must 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 Prescription Drug Products from Network Pharmacies, the Ancillary Charge is the difference between:

- The Prescription Drug Charge for the Prescription Drug Product.
- The Prescription Drug Charge 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 the Claims Administrator identifies as a Brand-name product, based on available data resources. This includes data sources such as, Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with the Claims Administrator or with an organization contracting on the Claims Administrator's behalf, to provide specific prescription Drug Products. This includes Specialty Prescription Drug Products. Not all Network Pharmacies are Designated Pharmacies.

Generic - a Prescription Drug Product: (1) is Chemically Equivalent to a Brand-name drug; or (2) that the Claims Administrator identifies as a Generic product based on available data resources. This includes data sources such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. Not all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Network Pharmacy - a pharmacy that has:

- entered into an agreement with the Claims Administrator or an organization contracting on the Claims Administrator's behalf to provide Prescription Drug Products to Covered Persons;
- agreed to accept specified reimbursement rates for dispensing Prescription Drug Products; and
- been designated by the Claims Administrator 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:

- 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 placed on a tier by the Claims Administrator PDL Management Committee.
- December 31st of the following calendar year

Pharmaceutical Product(s) – U.S. Food and Drug Administration (FDA) approved prescription medication or products administered in connection with a Covered Health Care Service by a Physician.

PPACA - Patient Protection and Affordable Care Act of 2010.

PPACA Zero Cost Share Preventive Care Medications – 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 Co-payment, Co-insurance, 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.
- Certain immunizations that have in effect a recommendation from *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 He*alth Resources and Services Administration.*

You may find out if a drug is a PPACA Zero Cost Share Preventive Medication as well as information on access to coverage of Medical Necessary alternatives by contacts your Plan Administrator at {WEB} or the telephone number on your ID card.

Predominant Reimbursement Rate - the charges incurred for a Prescription Drug Product not dispensed at a member pharmacy that will be considered covered expenses under the Plan. The Predominant Reimbursement Rate for a particular Prescription Drug Product includes the dispensing fee and sales tax. The Predominant Reimbursement Rate will be set at the Prescription Drug Product cost that the Claims Administrator's pharmaceutical benefits manager and most member pharmacies have agreed to for that Prescription Drug Product.

Prescription Drug Charge - the rate the Claims Administrator has agreed to pay the Claims Administrator's Network Pharmacies, for a Prescription Drug Product dispensed at a Network Pharmacy. The rate includes any applicable dispensing fee and sales tax.

Prescription Drug List - a list that places into tiers medications or products that have been approved by the U.S. Food and Drug Administration (FDA). This list is subject to the Claims Administrator's review and changed from time to time. You may find out which tier a particular Prescription Drug Product has been placed by contacting the Claims Administrator at {WEB} or by calling the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that the Claims Administrator designate for, placing 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 according to a Prescription Order or Refill. A Prescription Drug Product includes a medication that is generally appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers);
- Insulin;
- Certain vaccines/immunizations administered in a Network Pharmacy;
- Certain Injectable medications administered in a Network Pharmacy.
- 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; and
- blood glucose meters, including stand-alone continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice allows issuing such a directive.

Preventive Care Medications - 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 Cost (without application of any Copayment or Coinsurance) 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.

- 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 by calling Customer Care at the telephone number on your ID card.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses.

Therapeutically Equivalent - when Prescription Drug Products or Pharmaceutical Product as described in the Summary Plan Description have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. This fee includes any applicable dispensing fee and sales tax.

Section 11: Important Administrative Information: ERISA

This section includes information on the administration of the medical Plan, as well as information required of all SPDs by *ERISA* as defined in Section 12: *Defined Terms.* While you may not need this information for your day-to-day participation in the Plan, it is information you may find important.

Plan Sponsor and Administrator

ASCEN WORKFORCE, LLC is the Plan Sponsor and Plan Administrator of the ASCEN WORKFORCE, LLC Welfare Benefit Plan and has the authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator - Medical Plan

ASCEN WORKFORCE, LLC
548 MARKET ST # 28656
SAN FRANCISCO, CA 94104-5401
(415) 384-9739

Claims Administrator

United HealthCare Services, Inc., or its affiliates or designee 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 as directed by the Plan Administrator, through an administrative services agreement with the ASCEN WORKFORCE, LLC. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
PO Box 19032
Green Bay, WI 54307-9032

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:

Agent for Legal Process - Medical Plan

ASCEN WORKFORCE, LLC
548 MARKET ST # 28656
SAN FRANCISCO, CA 94104-5401
(415) 384-9739

Legal process may also be served on the Plan Administrator.

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:	ASCEN WORKFORCE, LLC Welfare Benefit Plan
Plan Number:	501
Employer ID:	871209507
Plan Type:	Welfare benefits plan
Plan Year:	July 01 - June 30
Plan Administration:	Level Funded
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 Plan 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 other documents available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies. Requests for available plan documents should be sent to the address provided in Section 8: *Questions, Complaints and Appeals*.

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 COBRA 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 8: *Questions, Complaints and Appeals*, 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 $147 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 domestic relations 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 N.W. 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.

The Plan's Benefits are administered by ASCEN WORKFORCE, LLC, the Plan Administrator. The Claims Administrator, United HealthCare Services, Inc. or its affiliate or designee is the Claims Administrator and processes claims for the Plan and provides appeal services; however, the Claims Administrator and ASCEN WORKFORCE, LLC are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or Out-of-Network provider. The Claims Administrator and ASCEN WORKFORCE, LLC are neither liable nor responsible for the treatment, services or supplies provided by Network or Out-of-Network providers.

Section 12: Defined Terms

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

Air Ambulance – medical transport by rotary wing Air Ambulance or fixed wing Air Ambulance as defined in 42 CFR 414.605.

Allowed Amount – for Covered Health Care Services, incurred while the Plan is in effect, Allowed Amounts are determined by the Claims Administrator or determined as required by law as shown in the Schedule of Benefits.

Allowed Amounts are determined in accordance with the Claims Administrator's reimbursement policy guidelines or as required by law. The Claims Administrator develops these guidelines, in its discretion, after review of all provider billings generally in accordance with one or more of the following methodologies.

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

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 Care Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

It may also provide Mental Health Care Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of added or changed provisions to the Plan. It is effective only when distributed by the Plan Sponsor or Plan Administrator. It is subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

Ancillary Services - items and services provided by out-of-Network Physicians at a Network facility that are any of the following:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology;
- Provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services, unless such items and services are 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 an out-of-Network Physician when no other Network Physician is available.

Annual Deductible – The total Allowed Amount or the Recognized Amount when applicable you must pay for Covered Health Care Services per calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in Section 4: *Schedule of Benefits*. This Plan does not require a Deductible.

Annual Visit Limits – The number of visits covered by the Plan over the course of a twelve month Plan year.

Annual Days of Service Limits – The number of days of service for minor diagnostic tests covered by the Plan over the course of a twelve-month Plan year.

Autism Spectrum Disorder – a condition, marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities and as listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or the *Diagnostic and Statistical Manual of Mental disorders* published by the *American Psychiatric Association*.

Benefits – your right to payment for Covered Health Care Services that are available under the Plan.

Calendar Year - January 1 through December 31.

Cellular Therapy - administration of living whole cells into a patient for the treatment of disease.

Chiropractic Treatment (adjustments) – a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion.
- Reduce pain.
- Increase function.

Claims Administrator - United HealthCare Services, Inc. and its affiliates or subcontractors, who provide certain claim administration and other services for the Plan

Coinsurance - the charge, stated as a percentage of Allowed Amounts or the Recognized Amount when applicable, that you are required to pay for Covered Health Care Services.

Company - ASCEN WORKFORCE, LLC

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

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

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Care Services.

NOTE: For Covered Health Care Services, you are responsible for paying the lesser of the following:

- The Copayment.
- The Allowed Amount or the Recognized Amount when applicable.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function.

Covered Health Care Service(s) - health care services, including Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating of a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in this SPD under Section 5: *Covered Health Care Services* and in the Schedule of Benefits.
- Not excluded in this SPD under Section 6: *Exclusions and Limitations*.

Covered Person - The Participant or a Dependent, but this term applies only while the person is enrolled under the Plan. References to "you" and "your" in this SPD to refer to a Covered Person.

Custodial Care - services that are any of the following non-Skilled Care services:

- Non-health-related services, such as assistance in activities of daily living (examples include eating, dressing, bathing, transferring and ambulating).
- Health-related services that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for more independent existence.

Definitive Drug Test - tests to identify specific medications, illicit substances and metabolites and is qualitative and quantitative to identify possible use of a drug.

Dependent - the Participant's legal Spouse or a child of the Participant or the Participant's Spouse. All references to the spouse of a Participant shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. As described in Section 2: When Coverage Begins, eligibility for enrollment and qualification as a

Dependent is administered by the Employer consistent with the eligibility rules noted in the Plan The term child includes:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Participant or the Participant's Spouse.
- A child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Claims Administrator is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order.*

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

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under age 26;
- A child is no longer eligible as a Dependent on the last day of the month during which the child reaches age 26 except as provided in Section 3: *When Coverage Ends* under *Coverage for a Disabled Dependent Child*.

The Participant must reimburse the Plan for any Benefits paid for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with the Claims Administrator, or with an organization contracting on the Claims Administrators' behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. Not all Network pharmacies or Network providers are Designated Dispensing Entities.

Domestic Partner - a person of the same or opposite sex with whom the Participant has a Domestic Partnership.

Domestic Partnership - A relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that is prohibited by law in the state of residence.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must be at least 18 years of age.
- They must share the same permanent residence and the common necessities of life.
- They must be mentally able to consent to contract.
- They must be financially interdependent and have furnished documents to support at least two of the following conditions of such financial interdependence:

  They have a single dedicated relationship of at least 6 months duration.

  They have joint ownership of a residence.

  They have at least two of the following:

  - A joint ownership of an automobile.
  - A joint checking, bank or investment account.
  - A joint credit account.
  - A lease for a residence identifying both partners as tenants.
  - A will and/or life insurance policies which designate the other as primary beneficiary.

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

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered DME.

- Not of use to a person in the absence of a disease or disability.
- Serves a medical purpose for the treatment of a Sickness or Injury.
- Primarily used within the home.

Eligible Person - an Employee of ASCEN WORKFORCE, LLC or other person connected to ASCEN WORKFORCE, LLC who meets the eligibility rules shown in both the Plan Sponsor's application and the Plan. An Eligible Person must reside within the United States. An employee residing in Hawaii is not an Eligible Person.

Emergency - a medical condition that manifests itself by acute symptoms of sufficient severity, (including severe pain) so that a prudent layperson who possessess an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Health Care Services - with respect to an Emergency.

- An appropriate medical screening examination (as required under section *1867 of the Social Security Act* 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; and
- Such further medical exam 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, 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)).*

Employee - an Employee of the Employer who meets the eligibility rules specified in the Plan, as described under *Who is Eligible for Coverage?* in Section 2: *When Coverage Begins*. An Employee must reside within the United States. An employee residing in Hawaii is not an Eligible Person.

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

Employer - ASCEN WORKFORCE, LLC

Enrolled Dependent - a Dependent who is covered under the Plan.

Experimental or Investigational Service(s) - 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 identified 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 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 5: *Covered Health Care Services*.
- The Claims Administrator may, as it determines, consider an otherwise Experimental or Investigational Service to be a Covered Health Care Service for that Sickness or condition if:
    - You are not a participant in a qualifying clinical trial, as described under Clinical Trials in Section 5: *Covered Health Care Services*; and
    - You have a Sickness or condition that is likely to cause death with one year of the request for treatment.

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.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

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.

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 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. Gestational Carrier does not provide the egg and it therefore not biologically related to the child.

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

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is mainly engaged in providing inpatient Health Care Services, for the short term care and treatment of injured or sick persons. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not mainly a place for rest, Custodial Care or care of the aged and is not a nursing home, 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 Care Services.

Initial Enrollment Period - the first period of time at new business when Eligible Persons may enroll themselves and their Dependents under the Plan. The initial enrollment period ends once the installation process is complete and a policy number is generated for the group

Injury - damage to the body, including all related conditions and symptoms.

Inpatient Rehabilitation Facility - any of the following that provides inpatient rehabilitation health care services (including physical therapy, occupational therapy and/or speech therapy) as authorized by law.

- A long term acute rehabilitation center,
- A hospital, or

- A special unit of a Hospital designated as an inpatient Rehabilitation Facility.

Inpatient Stay - a continuous stay that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient Mental Health Care 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. The most common IBT is Applied Behavior Analysis (ABA).

Intensive Outpatient Program - a structured outpatient treatment program.

- For Mental Health Care 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 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 certain circumstances when the need for more care is finite and predictable.

Late Enrollee - an Eligible Person or Dependent who enrolls for coverage under the Plan at a time other than the following:

- during the Initial Enrollment Period;
- during an Open Enrollment Period;
- during a special enrollment period as described in Section 2: *When Coverage Begins*; or
- within 31 days of the date a new Eligible Person first becomes eligible.

Manipulative Treatment (adjustment) - a form of care provided by chiropractors and osteopaths for diagnosed muscle, nerve and joint problems. Body parts are moved either by hands or by a small instrument to:

- Restore or improve motion
- Reduce pain
- Increase function.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that the Claims Administrator establishes. This list is subject to the Claims Administrator's periodic review and modification.

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

Medical Child Support Order - any judgment, decree, or order including approval of a settlement agreement which is made:

- under a state domestic relations law and requires child support or requires health and/or dental coverage for the child; or
- by a state agency under a state law for medical child support that is required under the federal Social Security Act.

The Medical Child Support Order must be issued by a court of competent jurisdiction, or issued through a state administrative process, and has the force and effect of law.

Medically Necessary – health care services that are all of the following as determined by the Claims Administrator or their designee:

- 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 use disorder 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) 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, 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 their 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 flexwork.uhc.com or by calling Customer Care at the telephone number on your ID card, and to Physicians and other health care professionals on 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 Care Services - services for the diagnosis and treatment of those mental health or psychiatric diagnostic categories that are listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or the *Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association*. The fact that a condition is listed in the current edition of the International Classification of Diseases section on Mental and Behavioral Disorders or *Diagnostic and Statistical Manual of Mental Disorders* published by *the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

Mental Health/Substance-Related and Addictive Disorders Delegate - the organization or individual, designated by the Claims Administrator, that provides or arranges Mental Health Care Services and Substance-Related and Addictive Disorders Services.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders or Diagnostic and Statistical Manual of Mental Disorders* published by *the American Psychiatric Association*. The fact that a condition is listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of Mental Disorders* published by *the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Care Service.

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

A provider may enter into an agreement to provide only certain Covered Health Care Services, but not all Covered Health Care 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 Care Services and products included in the participation agreement, and an out-of-Network provider for other Covered Health Care Services and products. The participation status of providers will change from time to time.

Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Network providers. The Schedule of Benefits will tell you if your plan offers Network Benefits and 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 as determined by the Claims Administrator or the Claims Administrator's designee, which is based on when the Pharmaceutical Product is reviewed and when utilization management strategies are implemented.
- December 31st of the following calendar year.

Open Enrollment Period - – thirty days prior to the renewal date of the Plan during which Eligible Persons may enroll themselves and their Dependents under the Plan.

Out-of-Network Benefits - the description of how Benefits are paid for Covered Health Care Services provided by Out-of–Network providers. The *Schedule of Benefits* will tell you if the plan offers Out-of-Network Benefits and how Out-of-Network Benefits apply.

Out-of-Pocket Limit - the maximum amount you may pay every Calendar Year. The Schedule of Benefits will tell you how the Out-of-Pocket Limit applies.

Partial Hospitalization/Day Treatment/High Intensity-Outpatient - a structured ambulatory program. The program may be freestanding or Hospital-based program and provides services for at least 20 hours per week.

Participant – An Eligible Person (who is not a Dependent) who is properly enrolled under the and who meets the eligibility rules specified in the Plan, as described under *Who is Eligible for Coverage?* in Section 2: *When Coverage Begins*. A Participant must reside within the United States.

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

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

Plan - the ASCEN WORKFORCE, LLC Welfare Benefit Plan

Plan Administrator - ASCEN WORKFORCE, LLC or its designee.

Plan Sponsor - ASCEN WORKFORCE, LLC.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Presumptive Drug Tests - test to determine the presence or absence of drugs or a drug class in which the results are indicated as negative or positive result.

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

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or 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 an inpatient or 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.

Qualified Medical Child Support Order (QMCSO): - the Medical Child Support Order.

- creates or recognizes the child's right to receive health and/or dental coverage;
- includes the required name and last known mailing address of the child and a reasonable description of the coverage to be provided;
- includes the time period to which the Medical Child Support Order applies; and
- does not require a type of coverage not otherwise provided by the plan, except as necessary under applicable law.

Recognized Amount - the amount which Copayment and Coinsurance, is based on for the below Covered Health Care Services when provided by out-of-Network providers.

- Non-Emergency Covered Health Care Services received at certain Network facilities by out-of-Network Physicians, when such services are either Ancillary Services, or non-Ancillary Services that have not satisfied the notice and consent criteria of section *2799B-2(d) of the Public Service A*ct. For the purpose of this provision, "certain Network facilities" are limited to a hospital (as defined in *1861(e) of the Social Security Act*), a hospital outpatient department, a critical access hospital (as defined in *1861(mm)(1) of the Social Security Act*), an ambulatory surgical center as described in section *1833(i)(1)(A) of the Social Security Act*, and any other facility specified by the Secretary.

The amount is based on one of the following in the order listed below as applicable:

- An *All Payer Model Agreement* if adopted,
- Applicable State law, or
- The lesser of the qualifying payment amount as determined under applicable law, or the amount billed by the provider or facility.

Note: Covered Health Care Services that use the Recognized Amount to determine your cost sharing may be higher or lower than if cost sharing for these Covered Health Care Services were determined based upon an Allowed Amount.

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 established and operated as required by law which provides Mental Health Care Services or Substance Related and Addictive Disorder Services.

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 Care Service, the difference in cost between a Semi–private Room and a private room is a Benefit only when a private room is Medically Necessary, or when a Semi–private Room is not available.

Service Fee - the periodic fee required for each Participant and each Enrolled Dependent, in accordance with the terms of the Plan.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *SPD* includes Mental Illness or substance-related and addictive disorders.

Skilled Care – skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- 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.
- Ordered by a Physician.
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- Requires clinical training in order to be delivered safely and effectively.
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist - 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.

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

Substance Related and Addictive Disorder 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 and Behavioral Disorders or *Diagnostic and Statistical Manual of Mental Disorders* published by *the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases* section on *Mental and Behavioral Disorders* or

Diagnostic and Statistical Manual of Mental Disorders published by *the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Care 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.

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.

Transitional Living - Mental Health Care Services and Substance-Related and Addictive Disorders provided through facilities, group homes and supervised apartments which provide 24-hour supervision, including those defined in the American Society of Addiction Medicine (ASAM) Criteria and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery. Please note, these living arrangements are also known as, supportive housing (including recovery residences).

Unproven Service(s) - services, including medications and devices, regardless of U.S. Food and Drug Administration (FDA) approval, that are determined not to be effective for treatment of the medical or behavioral health condition or not determined to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-designed randomized controlled trials or observational studies in the prevailing published peer-reviewed medical literature.

- Well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials.
- Individual well-designed randomized controlled trials.
- Well-designed observational studies with one or more concurrent comparison group(s) including cohort studies, case-control studies, cross-sectional studies, and systematic reviews (with or without meta analyses) of such studies.

The Claims Administrator has a process by which it compiles and reviews clinical evidence with respect to certain Health Care Services. From time to time, the Claims Administrator 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.

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, as the Claims Administrator determines, 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.

Urgent Care Center – an entity that provides Covered Health Care Services that are required to prevent serious deterioration of your health. These services are required as a result of an unforeseen Sickness, Injury, or the onset of sudden or severe symptoms.

Section 13: Consolidated Appropriations Act Summary

The Plan complies with the applicable provisions of the Consolidated Appropriations Act (the "Act") (P.L. 116-260).

No Surprises Act

Balance Billing

Under the Act, the No Surprises Act prohibits balance billing by out-of-Network providers in the following instances:

- When Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians.
- When non-Ancillary Services are received at certain Network facilities on a non-Emergency basis from out-of-Network Physicians who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described in the Act.
- When Emergency Health Care Services are provided by an out-of-Network provider.
- When Air Ambulance services are provided by an out-of-Network provider.

In these instances, the out-of-Network provider may not bill you for amounts in excess of your applicable Co-payment, Co-insurance or deductible (cost share). Your cost share will be provided at the same level as if provided by a Network provider and is determined based on the Recognized Amount.

For the purpose of this Summary, "certain Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary.

Determination of Payment to the Out-of-Network Provider:

When Covered Health Care Services are received from out-of-Network providers for the instances as described above, Allowed Amounts, which are used to determine the Plan's payment to out-of-Network providers, are based on one of the following in the order listed below as applicable:

- The reimbursement rate as determined by a state All Payer Model Agreement.
- The reimbursement rate as determined by applicable state law.
- The initial payment made by the Claims Administrator or the amount subsequently agreed to by the out-of-Network provider and the Claims Administrator.
- The amount determined by Independent Dispute Resolution (IDR).

Continuity of Care

The Act provides that if you are currently receiving treatment for Covered Health Care Services from a provider whose network status changes from Network to out-of-Network during such treatment due to termination (non-renewal or expiration) of the provider's contract, you may be eligible to request continued care from your current provider under the same terms and conditions that would have applied prior to termination of the provider's contract for specified conditions and timeframes. This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. If you would like help to find out if you are eligible for continuity of care Benefits, please call the telephone number on your ID card.

Provider Directories

The Act provides that if you receive a Covered Health Care Service from an out-of-Network provider and were informed incorrectly by the Claims Administrator prior to receipt of the Covered Health Care 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 cost sharing that would be no greater than if the service had been provided from a Network provider.

Health Care Reform Notice

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices
The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

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

OptumHealth Employee Assistance Emotional Support Line
Toll-free telephone access to Master's-level specialists for emotional health support, available 24 hour per day, 7 days per week, 365 days a year.

The EAP Emotional Support Line is available to employees and their family members enrolled in Unitedhealthcare FlexWork® plan. The Emotional Support Line connects members to Master's level EAP Specialists who are trained in motivational interviewing and behavioral health and can provide the member in-the-moment emotional support, referrals to community resources and collaborate with the member on an action plan/next steps. Members may access the Emotional Support Line either with a direct telephone number provided on the member portal or they can be transferred to the Emotional Support Line through the FlexWork call center. The EAP Specialists can also transfer the member back to the FlexWork call center should they have questions about their Unitedhealthcare FlexWork® medical benefits.

Federal Women's Health and Cancer Rights Act of 1998

The Federal Women's Health and Cancer Rights Act of 1998 requires that, for individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- 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 from all stages of mastectomy, including lymphedemas

These benefits will be provided subject to the same deductibles, copayments, and coinsurance provisions applicable to other medical and surgical benefits provided under your plan. They are also subject to medical insurance limitations and exclusions.