



Kiewit

Summary Plan Description

Peter Kiewit Sons', Inc.

Health and Welfare Plan

For Hawaii Residents

Group Number: 702561
Effective Date: January 1, 2023

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Introduction

We are pleased to provide you with this Summary Plan Description (SPD). This SPD describes your Benefits, as well as your rights and responsibilities, under the Plan.

How to Use this Document

We encourage you to read your SPD and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this SPD by reading (Section 1: What's Covered--Benefits) and (Section 2: What's Not Covered--Exclusions). You should also carefully read (Section 9: General Legal Provisions) to better understand how this SPD and your Benefits work. You should call the Claims Administrator if you have questions about the limits of the coverage available to you.

Many of the sections of the SPD are related to other sections of the document. You may not have all of the information you need by reading just one section. We encourage you to keep your SPD and any attachments for your future reference.

Please be aware that your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this SPD is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in (Section 10: Glossary of Defined Terms). You can

To continue reading, go to right column on this page.

refer to Section 10 as you read this document to have a clearer understanding of your SPD.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in (Section 10: Glossary of Defined Terms).

Your Contribution to the Benefit Costs

The Plan may require the Employee to contribute to the cost of coverage. Contact your Benefits representative for information about any part of this cost you may be responsible for paying.

Customer Service and Claims Submittal

Please make note of the following information that contains Claims Administrator department names and telephone numbers.

Customer Service Representative (questions regarding Coverage or procedures): As shown on your ID card.

Personal Health Support/Notification: As shown on your ID card.

Mental Health/Substance Use Disorder Administrator: As shown on your ID card.

To continue reading, go to left column on next page.

Claims Submittal Address:

United HealthCare Services, Inc.

Attention: Claims

P. O. Box 740800

Atlanta, Georgia 30374-0800

Requests for Review of Denied Claims and Notice of Complaints:

Name and Address for Submitting Requests:

United HealthCare Services, Inc.

Appeals

P. O. Box 30432

Salt Lake City, UT 84130-0432

Internet:

We also encourage you to visit the Claims Administrator's website, www.myuhc.com, to take advantage of several self-service features including: viewing your claims' status, ordering ID cards and finding Network Physicians in your area.

To continue reading, go to right column on this page.

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Section 1: What's Covered- Benefits

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible, Out-of-Pocket Maximum and Maximum Plan Benefit.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you to notify Personal Health Support or the Mental Health/Substance Use Administrator before you receive them.

Accessing Benefits

You can choose to receive Benefits from any Physician or provider.

You should show your identification card (ID card) every time you request health care services so that the provider will know that you are enrolled under the Plan.

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

- Covered Health Services are received while the Plan is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in (Section 8: When Coverage Ends) occurs.

To continue reading, go to right column on this page.

- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Plan.

Copayment

Copayment is the amount you pay each time you receive certain Covered Health Services. For a complete definition of Copayment, see (Section 10: Glossary of Defined Terms). Copayment amounts are listed on the following pages next to the description for each Covered Health Service. Please note that when Copayments are calculated as a percentage (rather than as a set dollar amount) the percentage is based on Eligible Expenses.

Eligible Expenses

Eligible Expenses for Covered Health Services, incurred while the Plan is in effect, are determined by us or by our designee once you have met your Annual Deductible. In almost all cases our designee is the Claims Administrator. For a complete definition of Eligible Expenses that describes how payment is determined, see (Section 10: Glossary of Defined Terms).

We have delegated to the Claims Administrator the discretion and authority to determine on our behalf whether a treatment or supply is a Covered Health Service and how the Eligible Expense will be determined.

You are responsible for paying, directly to the provider, the Copayment, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses, and any amounts in excess of any plan maximum.

To continue reading, go to left column on next page.

Notification Requirements

Prior notification is required before you receive certain Covered Health Services. You are responsible for notifying Personal Health Support before you receive these Covered Health Services.

For Mental Health/Substance Use Disorder Services you are responsible for notifying the Mental Health/Substance Use Disorder Administrator.

Services for which you must provide prior notification appear in this section under the *Must You Notify Personal Health Support?* column in the table labeled *Benefit Information*. Some of the services requiring notification include:

- Dental Services.
- Congenital Heart Disease Services.
- Durable Medical Equipment over \$1,000.
- Home Health Care.
- Hospital Inpatient Stay, all scheduled admissions;
- Maternity Care that exceeds 48 hours for normal delivery and 96 hours for Caesarian birth.
- Mental Health and Substance Use Disorder Services.
- Obesity surgery;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy and breast reduction surgery.
- Skilled Nursing/Inpatient Rehabilitation Facility Confinement.
- Transplant Services.
- Breast reduction and reconstruction (except for after cancer surgery), vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty. These services will not be covered when considered cosmetic in nature.

To continue reading, go to right column on this page.

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

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

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

Special Note Regarding Medicare

If you are enrolled for Medicare on a primary basis (Medicare pays before we pay Benefits under the Plan), the notification requirements described in this SPD do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in (Section 7: Coordination of Benefits). You are not required to notify Personal Health Support before receiving Covered Health Services when Medicare is the primary payer.

To continue reading, go to left column on next page.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms).	\$300 per Covered Person per calendar year, not to exceed \$600 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	\$3,000 per Covered Person per calendar year, not to exceed \$6,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does include the Annual Deductible.

Payment Term	Description	Amounts
Maximum Plan Benefit	<p>There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.</p> <p>Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act: Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.</p>	Unlimited

Benefit Information

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>1. Acupuncture Services Acupuncture services for pain therapy when provided by a licensed provider who is qualified in the use of acupuncture or an acupuncturist licensed by the state or certified by the National Commission of Acupuncturists.</p> <p>Where such Benefits are available, acupuncture is a Covered Health Service for the treatment of:</p> <ul style="list-style-type: none"> • Chronic pain, or • Nausea of Chemotherapy, or • Post-operative nausea, or • Nausea of early Pregnancy. 	No	20%	Yes	Yes
<p>2. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.</p>	No	<p><i>Ground Transportation:</i> 20%</p> <p><i>Air Transportation:</i> 20%</p>	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<h3>3. Ambulance Services - Non-Emergency</h3> <p>Transportation by professional ambulance, other than air ambulance, to and from a medical facility.</p> <p>Transportation by regularly-scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the required treatment.</p>	No	<p><i>Ground Transportation:</i> 20%</p> <p><i>Air Transportation:</i> 20%</p>	Yes	Yes
<h3>4. Congenital Heart Disease Services</h3> <p>Covered Health Services for Congenital Heart Disease (CHD) services when ordered by a Physician. CHD services may be received at a Congenital Heart Disease Resource Services program. Benefits are available for the CHD services when the services meet the definition of a Covered Health Service, and is not an Experimental or Investigational Service or an Unproven Service.</p> <p>Personal Health Support notification is required for all CHD services, including outpatient diagnostic testing, in utero services and evaluation.</p> <ul style="list-style-type: none"> • Congenital heart disease surgical interventions. • Interventional cardiac catheterizations. • Fetal echocardiograms. • Approved fetal interventions. 	<p><u>Designated Facility</u> Yes</p>	20%	Yes	Yes

**Description of
Covered Health Service**

**Must
You
Notify Personal
Health
Support?**

**Your Copayment
Amount**
% Copayments are
based on a percent of
Eligible Expenses

**Does
Copayment
Help Meet Out-
of-Pocket
Maximum?**

**Do You Need
to Meet Annual
Deductible?**

The services described under **Transportation and Lodging** below are Covered Health Services **ONLY** in connection with CHD services received at a Congenital Heart Disease Resource Services program.

CHD services other than those listed above are excluded from coverage, unless determined by Personal Health Support to be a proven procedure for the involved diagnoses.

Contact Personal Health Support at the telephone number on your ID card for information about CHD services.

Transportation and Lodging

Personal Health Support will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the recipient of CHD services and a companion are available under this Plan as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of CHD services for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- Eligible Expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people.
- Travel and lodging expenses are only available if the CHD recipient resides more than 50 miles from the Congenital Heart Disease Resource Services program.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> If the patient is an Enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the \$100 per diem rate. <p>There is a combined overall lifetime maximum Benefit of \$10,000 per Covered Person for all transportation and lodging expenses incurred by the CHD recipient and companion(s) and reimbursed under this Plan in connection with all CHD procedures.</p> <p style="text-align: center;">Notify Personal Health Support</p> <p>You should notify Personal Health Support as soon as CHD is suspected or diagnosed (in utero detection, at birth, or as determined and before the time an evaluation for CHD is performed).</p>				

5. Dental Services

Dental Services – Accident only

Yes

20%

Yes

Yes

Dental services when all of the following are true:

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

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

- A virgin or unrestored tooth, or
- A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy,

Description of Covered Health Service

Must You Notify Personal Health Support?

Your Copayment Amount
% Copayments are based on a percent of Eligible Expenses

Does Copayment Help Meet Out-of-Pocket Maximum?

Do You Need to Meet Annual Deductible?

is not a dental implant and functions normally in chewing and speech.

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

This section does not cover routine dental benefits or charges. Please see the Dental portion of this SPD for these benefits.

Dental Services – Other

Also covered is anesthesia and hospital charges for dental care provided to a Covered Person who is under age 6, who has a behavioral or physical disability, or who has a medical condition that requires hospital based care and/or anesthesia for dental treatment.

Notify Personal Health Support

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

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>6. Durable Medical Equipment</p> <p>Durable Medical Equipment that meets each of the following criteria:</p> <ul style="list-style-type: none"> • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. 	Yes, for items more than \$1,000.	20%	Yes	Yes
<p>If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment.</p>				
<p>Examples of Durable Medical Equipment include:</p>				
<ul style="list-style-type: none"> • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen concentrator units and the rental of equipment to administer oxygen. • Delivery pumps for tube feedings. • Braces that stabilize an injured body part are considered Durable Medical Equipment and are a Covered Health Service, including necessary adjustments to shoes to accommodate braces. • Braces that straighten or change the shape of a body part. • Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions. 				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • Braces that stabilize an injured body part and braces to treat curvature of the spine. <p>We provide Benefits for a single unit of Durable Medical Equipment (example one insulin pump) and provide repair for that unit.</p> <p>Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years.</p> <p>Personal Health Support will decide if the equipment should be purchased or rented. You must purchase or rent the Durable Medical Equipment from the vendor Personal Health Support identifies.</p> <p>At UnitedHealthcare’s discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person’s medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at anytime and are not subject to the three year timeline for replacement.</p> <p style="text-align: center;">Notify Personal Health Support</p> <p>Please remember that you should notify Personal Health Support before obtaining any single item of Durable Medical Equipment that costs more than \$1,000 (either purchase price or cumulative rental of</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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a single item).

7. Emergency Health Services

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

Emergency Health Services are provided 24 hours a day, 7 days a week, to Covered Persons with Emergency medical conditions without regard to whether the Covered Person, or an Emergency provider treating the Covered Person, obtained prior authorization for those health care services and supplies.

You will find more information about Benefits for Emergency Health Services in (Section 3: Obtaining Benefits).

There is no coverage for a non-emergency diagnosis in an Emergency Health Services facility.

Notify Personal Health Support

Please remember that if you are admitted to a Hospital as a result of an Emergency, you should notify Personal Health Support within two business days or as soon as reasonably possible.

Benefits will not be reduced for the outpatient Emergency Health Services.

Yes, but only for an Inpatient Stay.

20%

Yes

Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>8. Eye Examinations</p> <p>Eye examinations needed due to disease or injury received from a health care provider in the provider's office.</p> <p>This section does not cover routine vision exams or charges for eyeglasses or contact lenses. Please see the Vision Rider for these Benefits.</p>	No	20%	Yes	Yes
<p>9. Home Health Care</p> <p>Services received from a Home Health Agency that are both of the following:</p> <ul style="list-style-type: none"> • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home. Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled home health care is required, including Benefits for home IV therapy. <p>Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:</p> <ul style="list-style-type: none"> • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. 	Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. It requires clinical training in order to be delivered safely and effectively. It is not Custodial Care. <p>Personal Health Support will decide if skilled home health care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.</p>				

Notify Personal Health Support

Please remember that you should notify Personal Health Support five business days before receiving services.

10. Hospice Care

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

No

20%

Yes

Yes

Reimbursement for Hospice Care will be made with consideration of the minimum daily rate determined by the Health Care Financing

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Administration. A Hospice referral visit during which the patient is advised of Hospice care options is covered, whether or not the patient is eventually admitted to such care.</p> <p>Benefits are also available for up to five days of respite care.</p>				

11. Hospital - Inpatient Stay

Inpatient Stay in a Hospital. Benefits are available for:

Yes

20%

Yes

Yes

- Services and supplies received during the Inpatient Stay (operating room, surgical supplies, drugs, dressings, antibiotics, oxygen, hospital anesthesia services, general nursing services, blood transfusion services).
- Room and board in a Semi-private Room (a room with two or more beds).
- Room and board in, but not limited to, intensive care units, and other specialized care units

Notify Personal Health Support

Please remember that you should notify Personal Health Support as follows:

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

12. Infertility Services

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Covered Health Services for the diagnosis and treatment of an underlying medical condition causing infertility when provided by or under the direction of a Physician. Covered Health Services for outpatient in-vitro fertilization on a one-time basis, including for those who have obtained voluntary tubal ligation, when provided by or under the direction of a Physician. The patient and the patient's spouse must have a history of infertility for at least five years. <p>Covered Health Services for outpatient in vitro fertilization are payable same as for <i>Maternity Services</i>.</p> <p>The procedures must be performed at facilities conforming to either the American College of Obstetric and Gynecology guidelines or the American Fertility Society minimum standards.</p> <p>Prescription drugs will be covered under this Plan rather than under the Outpatient Prescription Drug Rider.</p>	NO	Same as Physician's Office Services, Professional Fees, Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>13. Injections received in a Physician's Office</p> <p>Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.</p> <p>Plan covers immunization for travel whether business or pleasure.</p>	No	<p>20% per injection <i>Travel</i> <i>Immunizations</i> 0%</p>	<p>Yes No</p>	<p>Yes No</p>
<p>14. Maternity Services – for Employees, Dependent Spouses and Dependent daughters</p> <p>Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services, including services provided by a nurse midwife, for prenatal care, postnatal care, delivery, and any related complications.</p> <p>There is a special prenatal program to help during Pregnancy. It is completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify Personal Health Support during the first trimester, but no later than one month prior to the anticipated childbirth.</p> <p>We will pay Benefits for an Inpatient Stay of at least:</p> <ul style="list-style-type: none"> 48 hours for the mother and newborn child following a vaginal delivery. 	Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> 96 hours for the mother and newborn child following a cesarean section delivery. <p>If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.</p> <p>Surrogate expenses are covered if insured is the surrogate.</p> <p style="text-align: center;">Notify Personal Health Support</p> <p>Please remember that you should notify Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described.</p>				

15. Mental Health Services

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

No

20%

Yes

Yes

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;

Description of Covered Health Service

Must You Notify Personal Health Support?

Your Copayment Amount
 % Copayments are based on a percent of Eligible Expenses

Does Copayment Help Meet Out-of-Pocket Maximum?

Do You Need to Meet Annual Deductible?

- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

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

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

Special Mental Health Programs and Services

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

Notification Required

Please remember that you should notify the MH/SUD

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card.</p>				
<hr/>				
<p>16. Neurobiological Disorders - Autism Spectrum Disorder Services The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders (otherwise known as neurodevelopmental disorders) that are both of the following:</p>	<p><i><u>OUTPATIENT</u></i></p>	<p>20%</p>	<p>Yes</p>	<p>Yes</p>
<ul style="list-style-type: none"> • Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and • Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning. 				
<p>These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.</p>	<p><i><u>INPATIENT</u></i></p>	<p>20%</p>	<p>Yes</p>	<p>Yes</p>
<p>Benefits include the following services provided on either an outpatient or inpatient basis:</p> <ul style="list-style-type: none"> • diagnostic evaluations and assessment; • treatment planning; • treatment and/or procedures; • referral services; 				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

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

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

Notification Required

Please remember that you should notify the MH/SUD Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card.

17. Newborn Care

No	<i>Well Baby</i> 20%	No	No
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Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
The Plan pays Benefits for newborn care.		<i>Sick Baby</i> 20%	Yes	Yes

17. Nutritional Counseling

Covered Health Services provided by a physician or registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Some examples of such medical conditions include:

- Diabetes mellitus.
- Coronary artery disease.
- Congestive heart failure.
- Severe obstructive airway disease.
- Gout.
- Renal failure.
- Phenylketonuria.
- Hyperlipidemias.

Benefits also will be covered for weight control sessions subject to the calendar year maximum.

Benefits are limited to four individual sessions per Covered Person each calendar year. This limit applies to non-preventive nutritional counseling services only.

No

20%

Yes

Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>When nutritional counseling services are billed as a preventive care service, these services will be paid as described under <i>Preventive Care Services</i> in this section.</p>				
<p>19. Ostomy Supplies The Plan pay Benefits for ostomy supplies including deodorants, filters, lubricants, appliance cleaners, adhesive and adhesive removers.</p>	No	20%	Yes	Yes
<p>20. Outpatient Surgery, Diagnostic and Therapeutic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:</p> <ul style="list-style-type: none"> • Surgery and related services. • Lab and radiology/X-ray. • One baseline mammogram for women age 35 to 39. One annual mammogram for women age 40 and older. Also, mammograms will be provided upon the recommendation of a Physician, for women of any age with a history of breast cancer or whose mother or sister has had a history of breast cancer. • Genetic Testing for breast cancer susceptibility regardless of family or medical history. • Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or other intravenous infusion therapy). <p>Benefits under this section include only the facility charge and the</p>	No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>charge for required services, supplies and equipment. Benefits for the professional fees related to outpatient surgery, diagnostic and therapeutic services are described under <i>Professional Fees for Surgical and Medical Services</i> below.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> below.</p>				

21. Physician's Office Services

Covered Health Services for preventive medical care.

No

0%

No

No

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

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

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. <p>Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 1, <i>What's Covered - Benefits</i>.</p> <p>Benefits are only available if breast pumps are obtained from a DME provider or Physician.</p> <p>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:</p> <ul style="list-style-type: none"> Which pump is the most cost effective; Whether the pump should be purchased or rented; Duration of a rental; Timing of an acquisition; <p>In addition to the services listed above, this preventive care benefit includes certain:</p> <ul style="list-style-type: none"> routine lab tests; 				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • diagnostic consults to prevent disease and detect abnormalities; • diagnostic radiology and nuclear imaging procedures to screen for abnormalities; • breast cancer screening and genetic testing; and • tests to support cardiovascular health. <p>These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.</p> <p>Covered Health Services for the diagnosis and treatment of a Sickness or Injury received in a Physician's office.</p>	No	20%	Yes	Yes
<p>22. Professional Fees for Surgical and Medical Services</p> <p>Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility including anesthesiologist services, intensive medical care, and medical/surgical consultations at the Hospital, or for Physician house calls.</p> <p>When these services are performed in a Physician's office, Benefits are described under <i>Physician's Office Services</i> above.</p>	No	20%	Yes	Yes
<p>23. Prosthetic Devices</p>	No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Prosthetic devices that replace a limb or body part including:</p> <ul style="list-style-type: none"> • Artificial limbs. • Artificial eyes. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. <p>If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.</p> <p>The prosthetic device must be ordered or provided by, or under the direction of a Physician. We provide Benefits for a single purchase, including repairs, of a type of prosthetic device. Benefits are provided for the replacement of each type of prosthetic device every five calendar years.</p> <p>At UnitedHealthCare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the five year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.</p>				

24. Reconstructive Procedures

Same as Physician's Office Services, Professional Fees,

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Reconstructive procedures - services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By improving or restoring physiologic function it is meant that the target organ or body part is made to work better. An example of a reconstructive procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.</p>	Yes	Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		
<p>Cosmetic Procedures - services are considered Cosmetic Procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures done to relieve such consequences as a reconstructive procedure. Reshaping a nose with a prominent "bump" would be a good example of a Cosmetic Procedure because appearance would be improved, but there would be no effect on function like breathing. This Plan does not provide Benefits for Cosmetic Procedures.</p>				
<p>Some services are considered cosmetic in some circumstances and reconstructive in others. This means that there may be situations in which the primary purpose of the service is to make a body part work better, whereas in other situations, the purpose would be to improve appearance and function (such as vision) is not affected. A good example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions improvement in appearance is the primary purpose of the procedure.</p>				
<p>Please note that Benefits for reconstructive procedures include</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. You can contact Personal Health Support at the telephone number on your ID card for more information about Benefits for mastectomy-related services.</p> <p style="text-align: center;">Notify Personal Health Support</p> <p>Please remember that you should notify Personal Health Support five business days before receiving services. When you provide notification, Personal Health Support can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage.</p>	No	20%	Yes	Yes

25. Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services for:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Orthoptic/vision therapy;
- Post-cochlear implant aural therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.

Description of Covered Health Service

Must You Notify Personal Health Support?

Your Copayment Amount
% Copayments are based on a percent of Eligible Expenses

Does Copayment Help Meet Out-of-Pocket Maximum?

Do You Need to Meet Annual Deductible?

Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician (when required by state law).

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.

Please note that the Plan excludes any type of therapy, service or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.

Speech Therapy

Services of a licensed speech therapist for treatment given to a Covered Person whose speech is impaired due to one of the following conditions:

- Development delay or cerebral palsy.
- Hearing impairment.
- Major congenital anomalies that affect speech such as, but not limited to, cleft lip and cleft palate.
- Speech impediment or speech dysfunction resulting from Injury, stroke, Congenital Anomaly, Sickness, cancer, autism spectrum disorder or is needed following the placement of a cochlear implant.

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services</p> <p>Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:</p> <ul style="list-style-type: none"> • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). <p>Please note that, in general, the intent of skilled nursing is to provide Benefits for Covered Persons who are convalescing from an Injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation and facility services which are less than those of a general acute Hospital but greater than those available in the home setting.</p> <p>The Covered Person is expected to improve to a predictable level of recovery.</p> <p>Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis. Accordingly, Benefits are NOT available when these services are required intermittently (such as physical therapy three times a week).</p> <p>Benefits are NOT available for custodial, domiciliary or maintenance care (including administration of enteral feeds) which, even if it is ordered by a Physician, is primarily for the purpose of meeting personal needs of the Covered Person or maintaining a level of function, as opposed to improving that function to an extent that</p>	Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>might allow for a more independent existence.</p> <p>(Custodial, domiciliary or maintenance care may be provided by persons without special skill or training. It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating and taking medication, as well as ostomy care, hygiene or incontinence care, and checking of routine vital signs.)</p> <p style="text-align: center;">Notify Personal Health Support</p> <p>Please remember that you should notify Personal Health Support as follows:</p> <ul style="list-style-type: none"> • For elective admissions: five business days before admission. • For non-elective admission: within one business day or the same day of admission. • For Emergency admissions: within two business days or the same day of admission, or as soon as is reasonably possible. 	No	20%	Yes	Yes
<p>27. Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy</p> <p>Benefits for Spinal Treatment include chiropractic and osteopathic manipulative therapy. Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.</p> <p>Benefits include diagnosis and related services and are limited to one</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>visit and treatment per day.</p> <p>Please note that the Plan excludes any type of therapy, service or supply including, but not limited to spinal manipulations by a chiropractor or other doctor for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.</p>				
<p>28. Substance Use Disorder Services</p> <p>Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider’s office.</p> <p>Benefits include the following services:</p> <ul style="list-style-type: none"> • diagnostic evaluations and assessment; • treatment planning; • treatment and/or procedures; • referral services; • medication management; • individual, family, therapeutic group and provider-based case management services; • crisis intervention; • Partial Hospitalization/Day Treatment; • services at a Residential Treatment Facility; and 	No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> Intensive Outpatient Treatment. <p>The Mental Health/Substance Use Disorder Administrator determines coverage for the inpatient treatment. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.</p> <p>You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.</p> <p><i>Special Substance Use Disorder Programs and Services</i> Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit. The Substance Use Disorder Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.</p>				
<p style="text-align: center;">Notification Required</p> <p>Please remember that you should notify the MH/SUD Administrator to receive inpatient Benefits. Please call the phone number that appears on your ID card.</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>29. Transplantation Services</p> <p>Covered Health Services for organ and tissue transplants when ordered by a Physician, including donor services. When transplantation services are received at a Designated United Resource Network Facility, your Copayment Amount is less. Benefits are available for transplants which meet the definition of a Covered Health Service and are not an Experimental or Investigational Service or an Unproven Service. Personal Health Support notification is required for all transplant services.</p>	Yes	<p><i>Designated URN Facility:</i> 0%</p> <p><i>non-Designated URN Facility:</i> 20%</p>	Yes	Yes
<p>Examples of transplants for which Benefits are available include but are not limited to:</p>				
<ul style="list-style-type: none"> • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. 				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<ul style="list-style-type: none"> • Small bowel transplants. • Multivisceral transplants. <p>Benefits are also available for cornea transplants that are provided by a Physician at a Hospital. We do not require that cornea transplants be performed at a Designated United Resource Network Facility.</p> <p>Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Personal Health Support to be a proven procedure for the involved diagnoses.</p> <p>Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact Personal Health Support at the telephone number on your ID card for information about these guidelines.</p> <p>Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.</p> <p>Transportation and Lodging – applicable to Designated URN Facilities only</p> <p>When a Designated URN Facility is used, Personal Health Support will assist the patient and family with travel and lodging arrangements.</p> <p>Expenses for travel and lodging for the transplant recipient and a companion are available. If the patient is an Enrolled Dependent minor child, the expenses of two companions will be covered.</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits are paid at a per diem rate of up to \$150 and will not exceed \$7,500 per calendar year.				
Notify Personal Health Support				
You should notify Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).				
30. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under <i>Physician's Office Services</i> earlier in this section.	No	20%	Yes	Yes
31. Hearing Aid Services Benefits are available for the purchase and fitting of hearing aids, when prescribed by a Physician.	No	20%	Yes	Yes
32. Wigs Wigs are a Covered Health Service when needed for loss of hair resulting from chemotherapy, radiation therapy or alopecia areata.	No	20%	Yes	Yes
33. Blood and Blood Products Coverage for blood and blood products including blood costs, blood bank services and blood processing.	No	Same as Other Covered Health Services		

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>34. Contraceptive Services and Supplies</p> <p>Contraceptive services and supplies are covered on the same basis as any other pregnancy-related treatment.</p> <p>"Contraceptive services" means Covered Health Services delivered by a Physician or a health care provider to promote the effective use of prescription contraceptive supplies or devices to prevent unwanted pregnancies.</p> <p>"Contraceptive supplies" means all Food and Drug Administration approved contraceptive drugs or devices used to prevent unwanted pregnancies.</p> <p>Oral contraceptives are covered under the Prescription Drug Rider. All other contraceptive supplies are covered under this Section.</p>	No	0%	No	No
<p>35. Diabetes Treatment</p> <p>Coverage for diabetes equipment, diabetes supplies and drugs, and diabetes self-management training programs when provided by or under the direction of a Physician.</p> <p>Diabetic supplies are limited to test strips for blood glucose monitors; visual reading and urine test strips; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.</p> <p>Diabetes self-management training includes training provided to a</p>	Yes, for items more than \$1,000	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount <small>% Copayments are based on a percent of Eligible Expenses</small>	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>Covered Person after the initial diagnosis in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies. Coverage is also provided for additional training when prescribed by a Physician upon diagnosis of a significant change in medical condition that requires a change in the self-management regime, and periodic continuing education training as warranted by the development of new techniques and treatments for diabetes.</p>	No	20%	Yes	Yes
<p>36. Medical Foods Coverage is provided for Medical Foods and Low-protein Modified Food Products prescribed for treatment of Inborn Error of Metabolism.</p> <p>"Medical Foods" means a food that is formulated to be consumed or administered enterally under the supervision of a Physician and is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.</p> <p>"Low protein Modified Food Product" means a food product that:</p> <ul style="list-style-type: none"> • • Is especially formulated to have less than one gram of protein per serving; • • Is prescribed or ordered by a Physician as Medically Necessary for the dietary treatment of an Inborn Error of Metabolism; and • • Does not include a food that is naturally low in protein. 	No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>"Inborn Error of Metabolism" means a disease caused by an inherited abnormality of the body chemistry of a person that is characterized by deficient metabolism, originating from congenital effects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat.</p>				
<p>37. Mental Health Services – Serious Mental Illnesses</p>				
<p>Benefits for treatment and diagnosis of serious mental illnesses are payable under the same terms and conditions, and which are no less extensive, than coverage provided under this Plan for physical illness. Any calendar year limits under this Plan for any outpatient or inpatient Mental Health Services or physical illness services do not apply to the Benefits for serious mental illness.</p>				
<p>"Serious mental illnesses" means schizophrenia, schizoaffective disorder, and bipolar mood disorder, as defined in the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders published by the American Psychiatric Association, which is of sufficient severity to result in substantial interference with the activities of daily living.</p>				
<p>38. Telehealth Services</p>				
<p>Coverage is provided for telehealth services the same as other Health Services.</p>	No	Same as Other Covered Health Services		
<p>"Telehealth" means the use of telecommunications services and enhanced services to deliver Health Services and information to</p>				

Description of Covered Health Service	Must You Notify Personal Health Support?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
<p>parties separated by distance. Standard telephone, facsimile transmissions, or both in the absence of other integrated information and data do not constitute telehealth services. No faceto face contact is required between a health care provider and a patient for services appropriately provided through telehealth.</p> <p>"Telecommunications service" means the offering of transmission between or among points specified by a user, of information of the user's choosing, including voice, data, image, graphics, and video without change in the form or content of the information, as sent and received, by means of electromagnetic transmission, or other similarly capable means of transmission, with or without the benefit of any closed transmission medium, and does not include cable services</p>				

Section 2: What's Not Covered—Exclusions

This section contains information about:

- How headings are used in this section.
- Medical services that are not covered. We call these Exclusions. It's important for you to know what services and supplies are not covered under the Plan.

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings. The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

Plan Exclusions

We will not pay or approve 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 Services, except as may be specifically provided for in (Section 1: Covered Health Services) or through a Rider to the

To continue reading, go to right column on this page.

SPD.

A. Alternative Treatments

1. Acupressure.
2. Aroma therapy.
3. Hypnotism, except that this exclusion will not apply to treatment of tobacco dependency under the Outpatient Mental Health and Substance Use Disorder Services.
4. Massage Therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
7. Holistic or homeopathic care.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners.
 - Air purifiers and filters.
 - Batteries and battery chargers.
 - Dehumidifiers.
 - Humidifiers.
6. Devices and computers to assist in communication and speech.
7. Home remodeling to accommodate a health need (such as, but

To continue reading, go to left column on next page.

not limited to, ramps and swimming pools).

C. Dental

1. Dental care except as described in (Section 1: What's Covered--Benefits) under the heading *Dental Services*.
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
 - Extraction, restoration and replacement of teeth.
 - Medical or surgical treatments of dental conditions.
 - Services to improve dental clinical outcomes.
3. Dental implants except for dental implants that are needed due to accident. (Some dental implants are covered under the Dental Benefits Plan if dentally necessary).
4. Dental braces.
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
 - Transplant preparation.
 - Initiation of immunosuppressives.
 - The direct treatment of acute traumatic Injury, cancer or cleft palate.
 - Hospitalizations and anesthesia are covered in limited circumstances as described in Section 1: What's Covered--Benefits) under the heading *Dental Services*.
6. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a Congenital Anomaly.

D. Drugs

To continue reading, go to right column on this page.

1. Prescription drug products for outpatient use that are filled by a prescription order or refill except as required by law for contraceptives and diabetes supplies in (Section 1: What's Covered – Benefits) if this Plan does not have a Prescription Drug Rider.
2. Self-injectable medications except as required by law for insulin in (Section 1: What's Covered – Benefits) if this Plan does not have a Prescription Drug Rider.

This exclusion does not include growth hormone therapy when determined to be medically necessary. Coverage will be provided at the same level as any other Covered Health Service.
3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments except as required by law for diabetes supplies listed in (Section 1: What's Covered – Benefits) if this Plan does not have a Prescription Drug Rider.

E. Experimental or Investigational Services or Unproven Services

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

F. Foot Care

To continue reading, go to left column on next page.

1. Except when needed for severe systemic disease (see below):
 - Routine foot care (including the cutting or removal of corns and calluses).
 - Nail trimming, cutting, or debriding.
 The Plan will cover 3 visits for foot care per calendar year for a Covered Person with severe systemic disease.
2. Hygienic and preventive maintenance foot care. Examples include the following:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.
 - Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
3. Treatment of flat feet.
4. Shoe orthotics, except that the Plan will cover custom shoe orthotics.

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies. Examples include:
 - Elastic stockings.
 - Ace bandages.
 - Gauze and dressings.
 - Syringes.
 - Diabetic test strips.
 Diabetic syringes and supplies are covered under the Outpatient Prescription Drug Rider.
3. Tubings, nasal cannulas, connectors and masks are not covered except when used with Durable Medical Equipment (as

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described in Section 1: What's Covered--Benefits).

H. Mental Health/Substance Use Disorder

In addition to all other exclusions listed in this Section 2, Exclusions listed directly below apply to services described under Mental Health Services, Neurobiological Disorders - Autism Spectrum Disorder Services and/or Substance Use Disorder Services in Section 1, What's Covered - Benefits.

1. services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance-related and addictive disorders that , in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:

- not consistent with generally accepted standards of medical practice for the treatment of such conditions;
- not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
- not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or
- not clinically appropriate for the patient's Mental Illness, substance-related and addictive disorders or condition based on generally accepted standards of medical practice and benchmarks.

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3. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
4. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;
5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorders;
6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act;
8. learning, motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
9. intellectual disabilities and autism spectrum disorder as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association;
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
11. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

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12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
13. intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders; and
14. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Individual and group nutritional counseling. This exclusion does not apply to nutritional counseling services that are billed as Preventive Care Services or to nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - nutritional education is required for a disease in which patient self-management is an important component of treatment; and
 - there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional;
3. Enteral feedings and other nutritional and electrolyte formulas, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism, and except for Medical Foods

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described in (Section 1: What's Covered – Benefits). Infant formula available over the counter is always excluded.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of 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.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.
Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered-- Benefits).
3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded. (Physician's Office Visits for weight management will be covered.)
5. Wigs except as described in (Section 1: What's Covered— Benefits).
6. Services received from a personal trainer.
7. Liposuction.

K. Providers

To continue reading, go to right column on this page.

1. Services performed by a provider who is a spouse, parent or child of the member. This includes any service the provider may perform on himself or herself.
2. Services performed by a Christian Science Nurse or Practitioner.

L. Reproduction

1. Health services and associated expenses for infertility treatment, except for diagnosis and treatment of an underlying medical condition causing infertility and except for in vitro fertilization as provided in (Section 1: What's Covered – Benefits).
2. Surrogate parenting, except if the surrogate is our insured person.
3. The reversal of voluntary sterilization.
4. Fees or direct payment to a donor for sperm or ovum donations.
5. Monthly fees for maintenance and/or storage of frozen embryos.
6. Contraceptive supplies and services, except that IUDs will be covered under the medical plan..
7. Fetal reduction surgery.
8. Health services associated with the use of non-surgical or drug-induced Pregnancy termination, except in cases of rape or incest.

This exclusion does not apply to Benefits for elective abortions, vasectomies and tubal ligations. Coverage for these services will be provided at the level as any other Covered Health Service.

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M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty, except that Covered Health Services are payable for a Covered Person on active military duty in the armed forces of the United States of America for as long as the Plan Administrator considers such person to be an active employee.

N. Transplants

1. Health services for organ and tissue transplants except those described in (Section 1: What's Covered--Benefits) unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan).
3. Health services for transplants involving mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.
5. Any multiple organ transplants not listed as a Covered Health Service under the heading *Transplantation Services* in (Section 1: What's Covered--Benefits) unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's

To continue reading, go to right column on this page.

transplant guidelines.

O. Travel

1. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision

1. Purchase cost of eye glasses or contact lenses (See Vision Rider).
2. Fitting charge for eye glasses or contact lenses (See Vision Rider).
3. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as radial keratotomy, laser, and other refractive eye surgery.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service – see the definition in (Section 10: Glossary of Defined Terms);

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

2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:

Required solely for purposes of career, education, camp, employment, insurance, marriage or adoption.

Related to judicial or administrative proceedings or orders.

Conducted for purposes of medical research.

Required to obtain or maintain a license of any type.

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(Physical exams and immunizations are covered by the Plan for the purposes of sports and travel only.)

3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country, to the extent permitted by law, and except that Covered Health Services are payable for a Covered Person on active military duty in the armed forces of the United States of America for as long as the Plan Administrator considers such person to be an active employee.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered to be dental in nature, including oral appliances, unless related to the bone.
9. Speech therapy except as noted under *Speech Therapy* in *Rehabilitation Services – Outpatient Therapy*.
10. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment of obstructive sleep apnea.
11. Sex transformation operations.

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12. Custodial care.
13. Domiciliary care.
14. Private duty nursing received on an inpatient basis.
15. Respite care except as described in (Section 1: What's Covered—Benefits).
16. Rest cures.
17. Psychosurgery.
18. Treatment of benign gynecomastia (abnormal breast enlargement in males).
19. Medical and surgical treatment of excessive sweating (hyperhidrosis).
20. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
21. Appliances for snoring.
22. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
23. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
24. Any charge for services, supplies or equipment advertised by the provider as free.
25. Any charges prohibited by federal anti-kickback or self-referral statutes.
26. Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
27. Outpatient rehabilitation services, Spinal Treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a

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medical problem from occurring or reoccurring.

28. Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
29. Chelation therapy, except to treat heavy metal poisoning.
30. Health care services provided in the emergency department of a Hospital or Alternate Facility that are not for an Emergency.

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Section 3: Obtaining Benefits

This section includes information about:

- Benefits for Covered Health Services.
- Your responsibility for notification.
- Emergency Health Services.

Benefits for Covered Health Services

Benefits are payable for Covered Health Services that are provided by or under the direction of a Physician or other provider.

Please note that Mental Health and Substance Use Disorder Services must be authorized by the Mental Health/Substance Use Disorder Administrator. Please see (Section 1: What's Covered–Benefits) under the heading for *Mental Health and Substance Use Disorder*.

Designated United Resource Network Facilities and Other Providers

If you have a medical condition that Personal Health Support believes needs special services, they may direct you to a Designated United Resource Network Facility or other provider chosen by them. If you require certain complex Covered Health Services for which expertise is limited, Personal Health Support may direct you to a non-Network facility or provider.

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In both cases, Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated United Resource Network Facility or other provider chosen by Personal Health Support.

Your Responsibility for Notifying Personal Health Support

You should notify Personal Health Support before getting certain Covered Health Services. The details are shown in the *Must You Notify Personal Health Support?* Column in (Section 1: What's Covered–Benefits).

Prior notification does not mean Benefits are payable in all cases. Coverage depends on the Covered Health Services that are actually given, your eligibility status, and any benefit limitations.

Personal Health Support

When you notify Personal Health Support as described above, they will work to implement the Personal Health Support process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Treatment Decision Support

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

This program offers:

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

Conditions for which this program is available include:

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

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

Emergency Health Services

We provide Benefits for Emergency Health Services when required for stabilization and initiation of treatment as provided by or under the direction of a Physician.

- If you are confined in a Hospital after you receive Emergency Health Services, Personal Health Support must be notified

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within two business days or on the same day of admission if reasonably possible.

- If you are admitted as an inpatient to a Hospital within 24 hours of receiving treatment for the same condition as an Emergency Health Service, you will not have to pay the Copayment for Emergency Health Services. The Copayment for an Inpatient Stay will apply instead.
- Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

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Section 4: When Coverage Begins

This section includes information about:

- How to enroll.
- If you are hospitalized when this coverage begins.
- Who is eligible for coverage.
- When to enroll.
- When coverage begins.

How to Enroll

To enroll, the Eligible Person must complete an enrollment form. The Plan Administrator or its designee will give the necessary forms to you along with instructions about submitting your enrollment form and any required contribution for coverage. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

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

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If You Are Eligible for Medicare

Your Benefits under the Plan may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits under the Plan may also be reduced if you are enrolled in a Medicare+Choice (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in (Section 9: General Legal Provisions) for more information about how Medicare may affect your Benefits.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	<p>Eligible Person usually refers to an Employee of ours who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as an Employee. For a complete definition of Eligible Person and Employee, see (Section 10: Glossary of Defined Terms). If two Eligible Persons of the Plan Sponsor are spouses of each other, each may enroll as an Employee or be covered as an Enrolled Dependent of the other, but neither can be enrolled more than once with the Plan Sponsor.</p> <p>Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without our written permission.</p>	<p>We determine who is eligible to enroll under the Plan.</p>
Dependent	<p>Dependent generally refers to the Employee's spouse (or Domestic Partner) and the Employee's (or the Domestic Partner's) children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms).</p> <p>Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as an Employee, only one parent may enroll the child as a Dependent according to the birthday rule.</p>	<p>We determine who qualifies as a Dependent.</p>

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
<p>Initial Enrollment Period</p> <p>The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.</p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>Coverage begins on the date identified by the Plan Administrator, if the Plan Administrator receives the completed enrollment form or enrollment is completed online and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.</p>
<p>Open Enrollment Period</p>	<p>Eligible Persons may enroll themselves and their Dependents.</p>	<p>The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator if the Plan Administrator receives the completed enrollment form or enrollment is completed online and any required contribution within 31 days of the date the Eligible Person becomes eligible to enroll.</p>
<p>New Eligible Persons</p>	<p>New Eligible Persons may enroll themselves and their Dependents.</p>	<p>Coverage begins on the first full day of active employment if the Plan Administrator receives the properly completed enrollment form or enrollment is completed online and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible to enroll and if the Employee pays any required contribution to the Plan Administrator for Coverage</p> <p>Coverage begins on the day of job status change if the Plan Administrator receives the properly completed enrollment form or enrollment is completed online and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible to enroll and if the</p>

When to Enroll

Who Can Enroll

Begin Date

Employee pays any required contribution to the Plan Administrator for Coverage.

If the Plan Administrator does not receive an enrollment form **or enrollment is not completed online**, the Eligible Person will be enrolled in the Plan with Employee only coverage for medical

Adding New Dependents

Employees may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Domestic Partnership
- Legal guardianship.
- Court or administrative order.

Coverage begins on the date of the event if the Plan Administrator received the completed enrollment form **or enrollment is completed online** and any required contribution for coverage within 31 days of the event that makes the new Dependent eligible.

Special Enrollment Period

An Eligible Person and/or 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

A special enrollment period applies:

- to an Eligible Person and any Dependents when one of the following events occurs:
- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Domestic Partnership

Event Takes Place (for example, a birth or marriage). Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form **or enrollment was completed online** and any required contribution within 31 days of the event.

Missed Initial Enrollment Period or Open Enrollment Period. Coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form **or enrollment is**

When to Enroll	Who Can Enroll	Begin Date
<p>was terminated for cause, or because required contributions were not paid on a timely basis.</p> <p>An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights.</p> <p>Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is elected.</p>	<ul style="list-style-type: none"> • for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true: • 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: <ul style="list-style-type: none"> Loss of eligibility (including, without limitation, 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 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 include the Eligible Person and/or Dependent. 	<p>completed online and any required contribution within 31 days of the date coverage under the prior plan ended.</p>
<p style="text-align: center;">In addition to the Special Enrollment Period events listed above, the following events are also included:</p>		

When to Enroll**Who Can Enroll****Begin Date**

(a) the Eligible Person or Eligible Dependent is covered under Medicaid or a State Child Health Insurance Program (SCHIP), and such coverage is terminated because of a loss of eligibility.

(b) the Eligible Person or Eligible Dependent becomes eligible for premium assistance under Medicaid or a State Health Insurance Program (SCHIP) with respect to coverage under the group health plan.

The Eligible Person must request enrollment in the group health plan no later than 60 days after the termination of coverage described in paragraph (a), or not later than 60 days after the date the Eligible Person or Eligible Dependent(s) is determined to be eligible for assistance as described in paragraph (b) above.

The Employer will not be assisting the Eligible Person or Eligible Dependent(s) with the premium assistance described in paragraph (b).

Section 5: How to File a Claim

This section provides you with information about:

- How and when to file a claim.

Filing a Claim for Benefits

When you receive Covered Health Services, you are responsible for requesting payment from us through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

You must submit a request for payment of Benefits within one year after the date of service. If a non-Network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced, in the Claims Administrator's discretion. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

If an Employee provides written authorization to allow direct payment to a provider, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Employee. We will not reimburse third parties who have purchased or been assigned benefits by Physicians or other providers.

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Coverage While Traveling Abroad

The Plan pays Benefits for Covered Persons while traveling outside the United States. Eligible Expenses for services incurred while outside the United States are reimbursed at the Network benefit level and are subject to the Annual Deductible. Emergency services received outside the United States will be paid at the network benefit level subject to the Annual Deductible. If you receive treatment while traveling outside the United States, you will have to pay for the services up-front and then submit a claim form along with the receipt and an itemized bill from the provider. Details on the procedures for filing a claim are described in this section. If you have any questions about Benefits while traveling abroad, please call UnitedHealthcare at the toll-free number on your ID card.

Pharmacy Benefit Claims

If you are asked to pay the full cost of a prescription when you fill retail or mail-order pharmacy and you believe that the Plan should have paid for it, you may submit a claim for reimbursement as set forth in the procedures for filing a post-service group health plan claim (described in this section). If you pay a copayment and you believe that the amount of the copayment was incorrect, you also may submit a claim for reimbursement as set forth in the procedures for filing a pharmacy reimbursement claim.

If a retail or mail order pharmacy fails to fill a prescription that you have presented, you may contact us by submitting a claim for coverage as set forth in the procedures for filing a pre-service health plan claim (described in this section).

Required Information

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

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- A. Employee's name and address.
- B. The patient's name, age and relationship to the Employee.
- C. The member number stated on your ID card.
- D. An itemized bill from your provider that includes the following:
 - Patient Diagnosis
 - Date(s) of service
 - Procedure Code(s) and descriptions of service(s) rendered
 - Charge for each service rendered
 - Provider of service Name, Address and Tax Identification Number
- E. The date the Injury or Sickness began.
- F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

Through the Claims Administrator, we will make a benefit determination as set forth below. Benefits will be paid to you unless either of the following is true:

- A. The provider notifies the Claims Administrator that your signature is on file, assigning benefits directly to that provider.
- B. You make a written request for the non-Network provider to be paid directly at the time you submit your claim.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of

To continue reading, go to right column on this page.

benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45 day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received, and may request a one time extension not longer than 15 days and pend your claim until all

To continue reading, go to left column on next page.

information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45 day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45 days period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a physician with knowledge of your medical condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72-hours after the Claims Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you filed an urgent claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

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You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48 hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

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

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

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Section 6: Questions and Appeals

This section provides you with information to help you with the following:

- You have a question or concern about Covered Health Services or your Benefits.
- You are notified that a claim has been denied because it has been determined that a service or supply is excluded under the Plan and you wish to appeal such determination.

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

What to Do First

If your question or concern is about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described in (How to File a Claim) you may appeal it as described below, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

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If you are appealing an Urgent Care Claim denial, please refer to the “Urgent Claim Appeals that Require Immediate Action” section below and contact Customer Service immediately.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday.

How to Appeal a Claim Decision

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

- The patient’s name and 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.

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

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

To continue reading, go to left column on next page.

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

Types of Claims

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

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

Review of an Appeal

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

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

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

Filing a Second Appeal

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

To continue reading, go to right column on this page.

receipt of the first level appeal determination. The Claims Administrator must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

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

Federal External Review Program

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

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

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

You or your representative may request a standard external review by sending a written request to the address set out in the

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

An external review request should include all of the following:

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

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

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

Standard External Review

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

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

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

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

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

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

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

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and

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- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

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

Upon receipt of a Final External Review Decision reversing UnitedHealthcare’s determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

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

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

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

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

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

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to

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IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

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

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable

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access to and copies of, all documents, records, and other information relevant to your claim for benefits.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

For appeals of pre-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims (as defined in How to File a Claim), the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent claims, see “Urgent Claim Appeals that Require Immediate Action” below.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator in writing within 60 days from receipt of the first level appeal decision.

For pre-service and post-service claim appeals, we have delegated to

To continue reading, go to left column on next page.

the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

Please note that the Claims Administrator's decision is based only on whether or not Benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your Physician.

Urgent Claim 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 by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

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Timing of Appeals Determinations

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

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

The tables below describe the time frames which you and the 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, the Claims Administrator must notify you within:	24 hours
You must then provide completed request for Benefits to the Claims Administrator within:	48 hours after receiving notice of additional information required
The Claims Administrator must notify you of the benefit determination within:	72 hours
If the 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
The 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 the 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, the Claims Administrator must notify you within:	5 days
If your request for Benefits is incomplete, the Claims Administrator must notify you within:	15 days
You must then provide completed request for Benefits information to the Claims Administrator within:	45 days
The 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
The Claims Administrator must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
The Claims Administrator must notify you of the second level appeal decision within:	15 days after receiving the second level appeal*

*The Claims Administrator may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond our control.

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	30 days
You must then provide completed claim information to the Claims Administrator within:	45 days
The 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
The Claims Administrator must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

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

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

Limitation of Action

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

You cannot bring any legal action against us or the Claims Administrator for any other reason unless you first complete all the

steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against us or the Claims Administrator you must do so within three years of the date you are notified of our final decision on your appeal or you lose any rights to bring such an action against us or the Claims Administrator.

Section 7: Coordination of Benefits

This section provides you with information about:

- What you need to know when you have coverage under more than one plan.
- Definitions specific to Coordination of Benefit rules.
- Order of payment rules.

Benefits When You Have Coverage under More than One Plan

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

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan.

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the Benefits it pays.

Definitions

For purposes of this section, terms are defined as follows:

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1. “Coverage Plan” is any of the following that provides Benefits or services for medical or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.

- a. “Coverage Plan” includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical Benefits under group or individual automobile contracts; and Medicare or other governmental Benefits, as permitted by law.
- b. “Coverage Plan” does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; Benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental Plans, unless permitted by law.

Each contract for coverage under a. or b. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

2. The order of benefit determination rules determine whether this Coverage Plan is a “Primary Coverage Plan” or “Secondary Coverage Plan” when compared to another Coverage Plan covering the person.

When this Coverage Plan is primary, its Benefits are determined before those of any other Coverage Plan and without considering any other Coverage Plan’s Benefits. When this Coverage Plan is secondary, its Benefits are determined after those of another Coverage Plan and may be reduced because of

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the Primary Coverage Plan's Benefits.

3. "Allowable Expense" means a health care service or expense, including deductibles and Copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides Benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, routine vision care, and outpatient prescription drugs are examples of expenses or services that are not Allowable Expenses under the Plan. The following are additional examples of expenses or services that are not Allowable Expenses:
 - a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.
 - b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
 - c. If a person is covered by two or more Coverage Plans that provide Benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 - d. If a person is covered by one Coverage Plan that calculates its Benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its Benefits or services on the basis of negotiated fees, the Primary

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Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.

- e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
4. "Closed Panel Plan" is a Coverage Plan that provides health Benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes Benefits for services provided by other providers, except in cases of Emergency or referral by a panel member.
5. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

When two or more Coverage Plans pay Benefits, the rules for determining the order of payment are as follows:

- A. The Primary Coverage Plan pays or provides its Benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.
- B. A Coverage Plan that does not contain a coordination of Benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of Benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan Hospital and surgical

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Benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide Non-Network Benefits.

- C. A Coverage Plan may consider the Benefits paid or provided by another Coverage Plan in determining its Benefits only when it is secondary to that other Coverage Plan.
- D. The first of the following rules that describes which Coverage Plan pays its Benefits before another Coverage Plan is the rule to use.
 - 1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a Dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a Dependent; and primary to the Coverage Plan covering the person as other than a Dependent (e.g. a retired employee); then the order of Benefits between the two Coverage Plans is reversed so that the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.
 - 2. Child Covered Under More Than One Coverage Plan. The order of Benefits when a child is covered by more than one Coverage Plan is:
 - a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:
 - 1) The parents are married;
 - 2) The parents are not separated (whether or not they ever have been married); or
 - 3) A court decree awards joint custody without specifying that one party has the responsibility to

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provide health care coverage.

- If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.
- b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.
- c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of Benefits is:
 - 1) The Coverage Plan of the custodial parent;
 - 2) The Coverage Plan of the spouse of the custodial parent;
 - 3) The Coverage Plan of the noncustodial parent; and then
 - 4) The Coverage Plan of the spouse of the noncustodial parent.
- 3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a Dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a Dependent of an actively working spouse will be determined under the rule labeled D(1).
- 4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal

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or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of Benefits, this rule is ignored.

5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
6. If a husband or wife is covered under this Coverage Plan as an Employee and as an Enrolled Dependent, the Dependent Benefits will be coordinated as if they were provided under another Coverage Plan, this means the Employee's benefit will pay first.
7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

Effect on the Benefits of this Plan

- A. When this Coverage Plan is secondary, it may reduce its Benefits by the total amount of Benefits paid or provided by all Coverage Plans that are primary to this Coverage Plan. As each claim is submitted, this Coverage Plan will:
 1. Determine its obligation to pay or provide Benefits under its plan;
 2. Determine the difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan and the benefit payments paid or provided by

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all Coverage Plans Primary to this Coverage Plan.

If there is a difference, this Coverage Plan will pay that amount. Benefits paid or provided by this Coverage Plan plus those of Coverage Plans that are primary to this Coverage Plan may be less than 100 percent of total Allowable Expenses.

- B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, Benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.
- C. This Coverage Plan reduces its Benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare Benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled for Medicare. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a Medicare+Choice (Medicare Part C) plan and receives non-covered services because the person did not follow all rules of that plan. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare Benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration

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facility, facility of the Uniformed Services, or other facility of the federal government. Medicare Benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.

- The person is enrolled under a Plan with a Medicare Medical Savings Account. Medicare Benefits are determined as if the person were covered under Medicare Parts A and B.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine Benefits payable under this Coverage Plan and other Coverage Plans. The Claims Administrator may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under this Coverage Plan and other Coverage Plans covering the person claiming Benefits.

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

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term “payment made” includes providing Benefits in the form of services, in which case “payment made”

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means reasonable cash value of the Benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the Benefits or services provided for you. The “amount of the payments made” includes the reasonable cash value of any Benefits provided in the form of services.

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Section 8: When Coverage Ends

This section provides you with information about all of the following:

- Events that cause coverage to end.
- The date your coverage ends.
- Continuation of coverage under federal law (COBRA).

General Information about When Coverage Ends

We may discontinue this Benefit Plan and/or all similar benefit plans at any time.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, we do not provide Benefits for health services incurred after your coverage end date, even if the underlying medical condition occurred before your coverage ended.

An Enrolled Dependent's coverage ends on the date the Employee's coverage ends or sooner if the Employee chooses to end the Dependent's coverage or as otherwise set forth in this SPD.

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Events Ending Your Coverage

Coverage ends on the earliest of the dates specified in the following table:

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the last day of the calendar month in which you are no longer eligible to be an Employee or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms “Eligible Person”, “Employee”, “Dependent” and “Enrolled Dependent.”
The Claims Administrator Receives Notice to End Coverage	Your coverage ends on the last day of the calendar month in which the Claims Administrator receives written notice from us instructing the Claims Administrator to end your coverage, or the date requested in the notice, if later.
Employee Retires	<p>Your coverage ends the last day of the calendar month in which the Employee retires under the Plan. We are responsible for providing written notice to the Claims Administrator to end your coverage.</p> <p>This provision applies unless we designate a specific coverage classification for retired or pensioned persons, and only if the Employee continues to meet any applicable eligibility requirements. We can provide you with specific information about what coverage is available for retirees.</p>

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Employee that coverage has ended on the date the Plan Administrator identifies in the notice:

Ending Event	What Happens
Fraud, Misrepresentation or False Information	The Employee commits an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include, but are not limited to, false information relating to another person's eligibility or status as a Dependent.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.

Coverage for a Handicapped Child

Coverage for an unmarried Enrolled Dependent child who is not able to be self-supporting because of mental retardation or a physical handicap will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental retardation or physical handicap.
- Depends mainly on the Employee for support.

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

We will ask you to furnish the Claims Administrator with proof of the child's incapacity and dependency within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before the Claims Administrator agrees to this extension of coverage for the child, the Claims Administrator may require that a Physician chosen by us examine the child. We will pay for that examination.

The Claims Administrator may continue to ask you for proof that the child continues to meet these conditions of incapacity and dependency. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

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

To continue reading, go to right column on this page.

Continuation of Coverage

If your coverage ends under the Plan, you may be entitled 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) is available only to Plans that are subject to the terms of COBRA.

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 below, whichever is earlier.

Continuation Coverage under Federal Law (COBRA)

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

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

- An Employee.
- An Employee's Enrolled Dependent Child, including a child born to or placed for adoption with the Employee during a period of continuation coverage under federal law.
- An Employee's Spouse.

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- In bankruptcy situations, certain retirees, their spouses or surviving spouses, and dependent children.

Although not required by federal law, the Plan also provides continuation coverage for your Domestic Partner and the children of your Domestic Partner who were covered under the Plan on the day before a qualifying event. (See definition of "Dependent" in Section 10, Glossary of Defined Terms, for a definition of "children of your Domestic Partner.") Such continuation coverage is identical to the COBRA continuation coverage that is available to an Employee's Spouse or Enrolled Dependent Child.

Qualifying Events for Continuation Coverage under COBRA

If the coverage of a Qualified Beneficiary would ordinarily terminate due to one of the following qualifying events, then the Qualified Beneficiary is entitled to continue coverage. The Qualified Beneficiary is entitled to elect the same coverage that she or he had on the day before the qualifying event.

- Termination of the Employee from employment with us (for any reason other than gross misconduct) or reduction of hours; or
- Death of the Employee; or
- Divorce or legal separation of the Employee; or
- Loss of eligibility by an Enrolled Dependent Child; or
- Entitlement of the Employee to Medicare benefits; or
- The Plan Sponsor filing for bankruptcy, under Title XI, United States Code, on or after July 1, 1986, but only for a retired Employee and his or her Enrolled spouse, surviving spouse, or Dependent Children. This is also a qualifying event for any retired Employee and his or her Enrolled spouse, surviving spouse, or Dependent Children if there is a substantial

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elimination of coverage within one year before or after the date the bankruptcy was filed.

Notification Requirements and Election Period for Continuation Coverage under COBRA

Notice Obligations

The Employee or other Qualified Beneficiary must notify Peter Kiewit Sons', Inc. Home Office Benefits Department, in writing, within 60 days of any of the following events:

- The Employee's divorce or legal separation;
- An Enrolled Dependent Child's loss of dependent status under the Plan;
- A disability determination by the Social Security Administration within the first 60 days of continuation coverage [note that the Plan may require that the notice of disability be furnished to it before the end of the first 18 months of continuation coverage in order for the individual to qualify for the 11-month extension]; or
- The occurrence of a second qualifying event during the period of continuation coverage.

The Employee or other Qualified Beneficiary must also notify the Peter Kiewit Sons', Inc. Home Office Benefits Department in writing within 30 days of the date a final determination is made by the Social Security Administration that the individual is no longer disabled.

Calculation of Notice Period and Notice Content Requirements

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Where the qualifying event is a divorce, an Enrolled Dependent Child ceasing to qualify as a dependent, or a second qualifying event, the time period for providing the notice is 60 days from the date the qualifying event occurs. If the individual would lose coverage at a date later than the qualifying event (such as the end of the month in which the event occurs), the time period for providing notice is 60 days from the date the individual would lose coverage. If you are unsure whether you will lose coverage at the date of the qualifying event or at a later date, please contact the Plan Administrator for additional guidance.

Where the qualifying event is a disability determination, the 60-day period for providing notice begins on the date of the disability determination. In the case of the 30-day period for providing notice to the Plan that an individual is no longer disabled, the notice period begins on the date of the final disability determination by the Social Security Administration.

Any written notice to the Peter Kiewit Sons', Inc. Home Office Benefits Department pursuant to this section must clearly indicate:

- The name of the Plan;
- The name of the Employee/Qualified Beneficiary;
- The nature of the qualifying event;
- The date of the qualifying event; and
- The name and signature of the individual making the submission.

If the Employee or other Qualified Beneficiary fails to notify the Peter Kiewit Sons', Inc. Home Office Benefits Department of the events listed as A through D above within the 60 day period, the

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Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If an Employee is continuing coverage under federal law, the Employee must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Temporary Extension of COBRA Election Period for Individuals Eligible for Trade Adjustment Assistance Pursuant to the Trade Act of 1974.

Individuals who become eligible for trade adjustment assistance ("TAA") under the Trade Act of 1974, and who did not elect continuation coverage during the 60-day COBRA election period that was the direct consequence of a TAA-related loss of coverage, may have a second 60-day COBRA election period. The second election period begins on the first day of the month in which the individual is determined to be a TAA-eligible individual, provided such election is made not later than 6 months after the date of the TAA-related loss of coverage.

A TAA-eligible individual may elect coverage for both himself or herself and his or her family. Any continuation coverage elected during the second election period will begin with the first day of the second election period, and not on the date on which coverage originally lapsed.

If you think you may be affected by this rule, you may wish to contact the Plan Administrator for more information.

Payment for COBRA Coverage

If a Qualified Beneficiary's coverage terminates due to a qualifying event, then the initial premium due to the Plan Administrator must be paid on or before the 45th day after electing continuation coverage.

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COBRA Terminating Events

COBRA continuation coverage under the Plan will end on the earliest of the following dates:

- A. Eighteen months from the date of the qualifying event, if the Qualified Beneficiary's coverage would have ended because the Employee's employment was terminated or hours were reduced (i.e., qualifying event A.).
- If a Qualified Beneficiary is determined to have been disabled under the Social Security Act at anytime within the first 60 days of continuation coverage for qualifying event A. then the Qualified Beneficiary may elect an additional 11 months of continuation coverage (for a total of 29 months of continued coverage) subject to the following condition: (i) notice of such disability must be provided within 60 days after the determination of the disability, 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; 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.
- B. Thirty-six months from the date of the qualifying event for an Enrolled Dependent whose coverage ended because of the death of the Employee, divorce or legal separation of the Employee,

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loss of eligibility by an Enrolled Dependent Child (i.e. qualifying events B., C., or D.).

- C. For the Enrolled Dependents of an Employee who was entitled to Medicare prior to a qualifying event that was due to either the termination of employment or work hours being reduced, eighteen months from the date of the qualifying event, or, if later, 36 months from the date of the Employee's Medicare entitlement.
- D. The date coverage ends for failure to make the first required premium (premium is not paid within 45 days)..
- E. The date, after electing continuation coverage, that coverage is first obtained under any other group health Plan.
- F. The date, after electing continuation coverage, that you or your covered Dependents first becomes entitled to Medicare.
- G. The date the entire Plan ends.
- H. The date coverage would otherwise terminate under the Plan as described in this section under the heading *Events Ending Your Coverage*.
- I. The date coverage ends for failure to make any other monthly premium (premium is not paid within 30 days of its due date).

If a Qualified Beneficiary is entitled to 18 months of continuation and a second qualifying event occurs during that time, the Qualified Beneficiary's coverage may be extended up to a maximum of 36 months from the date coverage ended because employment was terminated or hours were reduced. If the Qualified Beneficiary was entitled to continuation because the Plan Sponsor filed for bankruptcy (i.e. qualifying event F.), and the retired Employee dies during the continuation period, then the other Qualified Beneficiaries shall be entitled to continue coverage for 36 months from the date of the Employee's death. Terminating events B through G described in this section will apply during the extended

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continuation period.

Continuation coverage for Qualified Beneficiaries whose continuation coverage terminates because the Employee becomes entitled to Medicare may be extended for an additional period of time. Such Qualified Beneficiaries should contact the Plan Administrator for information regarding the continuation period.

How does Medicare affect COBRA coverage?

The entitlement to Medicare does not constitute a “second qualifying event” under COBRA (which extends the COBRA coverage period of an affected former employee’s spouse and dependents from 18 to 36 months) unless entitlement to Medicare would, by itself, result in the employee’s loss of health coverage. Under the Medicare Secondary Payer rules, an active employee’s entitlement to Medicare (or the entitlement of such active employee’s spouse) due to age cannot affect his right to health care coverage from the employer and, therefore, can never be an initial qualifying event. But if you are terminated during the 18 months following your entitlement to Medicare, then the termination of employment coupled with the initial entitlement would extend the COBRA coverage period for your spouse and dependents from 18 to 36 months.

Continuation Coverage under State Law

If coverage stops because the Employee is hospitalized or otherwise prevented by Sickness from working, the Employee may continue the health coverage then in effect. The Employee will have to make payments to the Employer for the coverage. These payments will not exceed the amount that the Employee was paying before becoming hospitalized or disabled by sickness. Coverage will

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continue while the Plan is in force. It will stop on the later of the following, so long as the Employee makes payments for the coverage:

- Three months following the month in which the Employee became hospitalized or otherwise prevented by Sickness from working.
- The period for which the Employer undertakes the payment of the Employee’s regular wages.

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Section 9: General Legal Provisions

This section provides you with information about:

- General legal provisions concerning your Plan.

Plan Document

This Summary Plan Description presents an overview of your Benefits. Except as otherwise provided in the official Plan Document, in the event of any discrepancy between this Summary Plan Description and the official Plan Document, the terms of this Summary Plan Description shall govern.

Relationship between Claims Administrator and Us

The relationships between us and the Claims Administrator are solely contractual relationships between independent contractors. The Claims Administrator is not our agent nor our Employee. Neither we nor any of our Employees are agents or Employees of Claims Administrator.

We do not provide health care services or supplies, nor do we practice medicine.

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Your Relationship with Providers

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

- You are responsible for choosing your own provider.
- You must decide if any provider treating you is right for you. This includes Managed Indemnity providers you choose and providers to whom you have been referred.
- You must decide 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 us is that of employer and Employee, Dependent or other classification as defined in the Plan.

Incentives to Providers

The Claims Administrator pays Managed Indemnity providers through various types of contractual arrangements, some of which 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 Managed Indemnity providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness.
- Capitation – a group of Managed Indemnity providers receives a monthly payment from the Claims Administrator for each Covered Person who selects a Managed Indemnity provider within the group to perform or coordinate certain health services. The Managed Indemnity providers receive this monthly

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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.

The methods used to pay specific Managed Indemnity providers may vary. From time to time, the payment method may change. If you have questions about whether your Managed Indemnity provider's contract includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact the Claims Administrator at the telephone number on your ID card. They can advise whether your Managed Indemnity provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes the Claims Administrator may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact the Claims Administrator if you have any questions.

Interpretation of Benefits

We and the Claims Administrator have sole and exclusive discretion to do all of the following:

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.

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- Make factual determinations related to the Plan and its Benefits.

We and the Claims Administrator may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

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

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, 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 in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Plan

We reserve the right, in our sole discretion and without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Plan. Plan Amendments and Riders are effective on the date we specify.

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

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Any change or Amendment to or termination of the Plan, its Benefits or its terms and conditions, in whole or in part, shall be made solely in a written Amendment (in the case of a change or Amendment) or in a written resolution (in the case of a termination), whether prospective or retroactive, to the Plan, in accordance with the procedures established by us. Covered Persons will receive notice of any material modification to the Plan. No one has the authority to make any oral modification to the SPD.

Clerical Error

If a clerical error or other mistake occurs, that error does not create a right to Benefits. These errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements. It is your responsibility to confirm the accuracy of statements made by us or our designees, including the Claims Administrator, in accordance with the terms of this SPD and other Plan documents.

Information and Records

At times we or the Claims Administrator may need additional information from you. You agree to furnish us and/or the Claims Administrator with all information and proofs that we may reasonably require regarding any matters pertaining to the Plan. If you do not provide this information when we request it we may delay or deny payment of your Benefits.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish us or the Claims Administrator with all information or copies of records relating to the services provided to you. We or the Claims Administrator have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Employee's enrollment form. We and the Claims Administrator

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agree that such information and records will be considered confidential.

We and the Claims Administrator have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Plan, we, the Claims Administrator, and our related entities may use and transfer the information gathered under the Plan for research and analytic purposes.

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

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

In some cases, we or 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 necessary. Such designees have the same rights to this information as the Plan Administrator.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Physician of our choice examine you at our expense.

Workers' Compensation not Affected

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

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insurance.

Medicare Eligibility

Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Plan), you **should** enroll for and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in (Section 7: Coordination of Benefits), we will pay Benefits under the Plan as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a Medicare+Choice (Medicare Part C) Plan on a primary basis (Medicare pays before Benefits under the Plan), you **should** follow all rules of that Plan that require you to seek services from that Plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Plan as if you had followed all rules of the Medicare+Choice Plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement.

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Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is alleged to be responsible.

Subrogation – Example

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

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Reimbursement – Example

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

The following persons and entities are considered third parties:

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- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
 - providing any relevant information requested by the Plan;
 - signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
 - responding to requests for information about any accident or injuries;
 - making court appearances;

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- obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
- complying with the terms of this section.

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

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of

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associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal

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representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make

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determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

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

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

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

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

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

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

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

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- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if either of the following apply:

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

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

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

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from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

Limitation of Action

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

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

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Section 10: Glossary of Defined Terms

This section:

- Defines the terms used throughout this SPD.
- Is not intended to describe Benefits.

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

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

- Pre-scheduled surgical services.
- Emergency Health Services.
- Pre-scheduled rehabilitative, laboratory or diagnostic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment – any attached written description of additional or revised provisions or Benefits to the Plan. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

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Annual Deductible – the amount you must pay for Covered Health Services in a calendar year before we will begin paying for Benefits in that calendar year.

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

Benefits – your right to payment for Covered Health Services that are available under the Plan. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Plan, including this SPD and any applicable Riders and Amendments.

BMI: a measure used in obesity risk assessment to determine the degree of obesity by approximating the measure of total body fat as compared with the assessment of body weight alone. Also referred to as Body Mass Index.

Claims Administrator – the company, or its affiliate, that provides certain claim administration services for the Plan.

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

Congenital Heart Disease Program – the Claims Administrator’s program made available by the Employer to Employees. The Congenital Heart Disease Program provides information to Employees or their Covered Dependents with congenital heart disease and offers access to additional centers for the treatment of congenital heart disease.

Copayment – the charge you are required to pay for certain Covered Health Services. A Copayment may be either a set dollar amount or a percentage of Eligible Expenses.

Cosmetic Procedures – procedures or services that change or

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improve appearance without significantly improving physiological function, as determined by Personal Health Support on our behalf.

Covered Health Service(s) –those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What’s Covered–Benefits) as a Covered Health Service, which is not excluded under (Section 2: What’s Not Covered–Exclusions), including Experimental or Investigational Services and Unproven Services.

Covered Health Services must be provided:

- When the Plan is in effect;
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description; and
- Only when the person who receives services is a Covered Person and meets all eligibility requirements specified in the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

Covered Person – either the Employee or an Enrolled Dependent, but this term applies only while the person is enrolled under the Plan. References to “you” and “your” throughout this SPD are references to a Covered Person.

Custodial Care – services that:

- Are non-health related services, such as assistance in activities of daily living (including but not limited to feeding, dressing, bathing, transferring and ambulating); or
- Are health-related services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing; or
- Do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent – the Employee’s legal spouse or an unmarried Dependent child of the Employee or the Employee’s spouse. All references to the spouse of an Employee shall include a Domestic Partner. The term child includes any of the following:

- 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 Employee or the Employee’s spouse.

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

- A Dependent includes any Dependent child less than 26 years of age.

A Dependent includes a child who is related to the Employee without regard to any of the following facts:

- The child does not reside with the Employee.
- The child is born out of wedlock.

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- The child is not claimed as a dependent on the Employee's federal or state income tax.
- The child lives outside the service area.

The Employee must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A child entitled to coverage due to a court order will be able to be enrolled without giving proof of insurability and regardless of any enrollment season restriction. If the noncustodial parent is the parent with health coverage and does not enroll the child, we will help the custodial parent, the state agency for Medicaid, or the state agency enforcing the support order, to enroll the child and to make claims on behalf of that child. We will not cancel or revoke enrollment of the child, or eliminate coverage, unless one of the following happens:

- The Employer receives satisfactory written evidence that the order requiring coverage is no longer in effect.
- The Employer receives confirmation that the child is enrolled in other comparable coverage that will take effect not later than the effective date of disenrollment under this Plan.
- The Employer has eliminated dependent health coverage for all its Employees.
- The Employee is no longer eligible for coverage.

A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee.

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Designated United Resource Network Facility – a Hospital that the Claims Administrator names as a Designated United Resource Network Facility. A Designated United Resource Network Facility has entered into an agreement with the Claims Administrator to render Covered Health Services for the treatment of specified diseases or conditions. A Designated United Resource Network Facility may or may not be located within our geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated United Resource Network Facility.

Domestic Partner – a person of the opposite or same sex with whom the Employee has established a Domestic Partnership.

Domestic Partnership – consists of the subscriber and one other person of the same or opposite sex. Such persons must satisfy all of the following requirements:

- You and the individual have registered as Domestic Partners with a government registry authorized to perform such registrations;
- You and your Domestic Partner are not related by blood or a degree of closeness which would prohibit marriage in the laws of the state in which you reside;
- Both you and your Domestic Partner are of the age of consent in your state of legal residence;
- Both you and your Domestic Partner are mentally competent to enter into a contract;
- You and the individual are the sole Domestic Partner of each other; and
- Neither you nor your Domestic Partner are currently married (to anyone other than each other) under either statutory or common law.

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

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.

Eligible Expenses – the amount we will pay for Covered Health Services, incurred while the Plan is in effect, are determined as stated below:

Eligible Expenses are based on available data resources of competitive fees in that geographic area.

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

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association.
- As reported by generally recognized professionals or publications.
- As used for Medicare.

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- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

Eligible Person – an employee, including part-time and temporary employees, of the Plan Sponsor who has worked at least 20 hours a week for four consecutive weeks. If the enrollment date is the “first of the month”, coverage will begin on the first of the month following four consecutive weeks of working at least 20 hours each week. An Eligible Person must reside within the United States.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

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

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency. Emergency Health Services are provided 24 hours a day, 7 days a week, to Covered Persons with Emergency medical conditions without regard to whether the Covered Person, or an emergency provider treating the Covered Person, obtained prior authorization for those health care services and supplies.

Employee – an Eligible Person who is properly enrolled under the Plan. The Employee is the person (who is not a Dependent) on whose behalf the Plan is established.

Enrolled Dependent – a Dependent who is properly enrolled under the Plan.

Experimental or Investigational Services – medical, surgical,

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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 in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or.
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- If you are not a participant in a qualifying Clinical Trial and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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Hospital – an institution, operated as required by law, that is both of the following:

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

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

Initial Enrollment Period – the initial period of time, as determined by the Plan Administrator, during which Eligible Persons may enroll themselves and their Dependents under the Plan.

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

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

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

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

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

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

Mental Health/Substance Use Disorder Administrator – the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Plan.

Mental Illness – those mental health or psychiatric diagnostic categories that are listed in the current Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services

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and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Open Enrollment Period – a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan. The Plan Administrator will determine the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum – the maximum amount you pay out-of-pocket every calendar year. Once you reach the Out-of-Pocket Maximum, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year.

The following costs will never apply to the Out-of-Pocket Maximum:

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- The amount of any reduced Benefits if you don't notify Personal Health Support as described in (Section 1: What's Covered—Benefits) under the *Must You Notify Personal Health Support?* Column.
- Charges that exceed Eligible Expenses.

Even when the Out-of-Pocket Maximum has been reached, the following will not be paid at 100%:

- Any charges for non-Covered Health Services.
- The amount of any reduced Benefits if you don't notify Personal Health Support as described in (Section 1: What's Covered—

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Benefits) under the *Must You Notify Personal Health Support?* Column.

- Charges that exceed Eligible Expenses.

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

Personal Health Support- a program provided by the Claims Administrator designed to encourage an efficient system of care for Covered Persons by identifying and addressing possible unmet covered health care needs.

Physician – any Doctor of Medicine, “M.D.”, or Doctor of Osteopathy, “D.O.”, who is properly licensed and qualified by law.

Please Note: Any advanced practice registered nurse, chiropractor, clinical social worker, dentist, nurse midwife, podiatrist, psychologist, 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 we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - Peter Kiewit Sons', Inc. Welfare Benefits Plan.

Plan Administrator - is the Peter Kiewit Sons', Inc. or its designee as that term is defined under ERISA.

Plan Sponsor - Peter Kiewit Sons', Inc. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Pregnancy - includes all of the following for eligible employees, spouses and eligible dependent daughters only:

- Prenatal care.

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

Preventive care – Medical services aimed at early detection and intervention. Focuses on wellness, health promotion, and other activities that reduce the likelihood of illness or Injury.

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

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

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

Rider - any attached written description of additional Covered Health Services not described in this SPD. Riders are subject to all conditions, limitations and exclusions of the Plan except for those that are specifically amended in the Rider.

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

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 1, *What's Covered--Benefits*.

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

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance use disorder, regardless of the cause or origin of the Mental Illness or substance use disorder.

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

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

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

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

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

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Unproven Services - services that are not consistent with conclusions of prevailing medical research which demonstrate that the health service has a beneficial effect on health outcomes and that are not based on trials that meet either of the following designs.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we and the Claims Administrator may, in our discretion, determine that an Unproven Service meets the definition of a Covered Health Service for that Sickness or condition. For this to take place, we and the Claims Administrator must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Urgent Care Center - a facility, other than a Hospital, that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

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Riders and Attachments

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Outpatient Prescription Drug Rider

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Outpatient Prescription Drug Rider

This Rider to the Summary Plan Description provides Benefits for outpatient Prescription Drug Products.

Benefits are provided for outpatient Prescription Drug Products at a Network Pharmacy.

When we use the words "we," "us," and "our" in this document, we are referring to the Plan Sponsor. When we use the words "you" and "your" we are referring to people who are Covered Persons as the term is defined in the Summary Plan Description (Section 10: Glossary of Defined Terms).

NOTE: The Coordination of Benefits provision (Section 7: Coordination of Benefits) in the Summary Plan Description does not apply to Prescription Drug Products covered through this Rider. Prescription Drug Product Benefits will not be coordinated with those of any other health coverage plan.

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Introduction

Coverage Policies and Guidelines

The Claims Administrator's Pharmacy and Therapeutics Committee is the national committee which reviews all drugs that are newly approved by the FDA. The Pharmacy and Therapeutics Committee evaluates the use of the newly approved prescription drug. The Pharmacy and Therapeutics Committee objectively evaluates drugs for therapeutic treatment and safety. The evaluation includes, but is not limited to: safety and efficacy; supply limits; notification requirements. The Pharmacy and Therapeutics Committee makes recommendations to the Claims Administrator's Preferred Drug List Management Committee for final approval. This two-step process is designed to establish coverage policies and guidelines that promote quality and cost-effective drug therapy.

Even after a drug is included on the Preferred Drug List, this evaluation continues at least annually or as new information becomes available.

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 us during regular business hours.

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

You may seek reimbursement from us as described in the Summary Plan Description (Section 5: How to File a Claim). When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment, Ancillary Charge and any deductible that applies.

Limitation on Selection of Pharmacies

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

Rebates and Other Payments

The Claims Administrator may receive rebates for certain Brand-name drugs included on the Preferred Drug List. These rebates are not considered in calculating any percentage Copayments. We or the Claims Administrator are not required to pass on to you, and do not pass on to you, amounts payable to us or the Claims Administrator under rebate programs or other such discounts.

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Coupons and Incentives

At various times the Claims Administrator may offer coupons or other incentives for certain drugs. Only your doctor can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

The Claims Administrator may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

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Section 1: What's Covered-- -Prescription Drug Benefits

We provide Benefits under the Plan for outpatient Prescription Drug Products:

- Designated as covered at the time the Prescription Order or Refill is dispensed when obtained from a Network Pharmacy.
- Refer to exclusions in your Summary Plan Description (Section 2: What's Not Covered--Exclusions) and as listed in Section 2 of this Rider.

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

When a Brand Name Drug Becomes Available as a Generic

When a Prescription Drug Product becomes available as a Generic, your Copayment may change.

You will pay the Generic Copayment, if you choose to receive the

Generic drug, or you may pay the higher Copayment if your Physician determines that you should continue receiving the Brand-name. You will pay the higher Copayment and an Ancillary Charge for a Brand-name Prescription Drug Product if you choose to continue receiving the Brand-name.

The terms "generic" and "brand-name" are used in the health care industry in many different ways. To be sure that you know whether a drug is classified as Brand-name or Generic by use, please review the definitions contained in *Section 3: Glossary of Defined Terms* at the end of this Rider. You should also check the current classification on the Preferred Drug List through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the *Benefit Information* table. For a single Copayment, 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 the Claims Administrator has developed. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

You may obtain a current list of Prescription Drug Products that have been assigned maximum quantity levels for dispensing through the Internet at www.myuhc.com or by calling the telephone number on your ID card. The list is subject to periodic review and modification.

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Notification Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to notify the Claims Administrator or its designee. The reason for notification is to determine whether the Prescription Drug Product, in accordance with the Claims Administrator's approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not Experimental, Investigational or Unproven.

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

The list of Prescription Drug Products requiring notification is subject to periodic review and modification. You may obtain a current list of Prescription Drug Products that require notification through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

If the Claims Administrator is not notified before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. You may seek reimbursement as described in the Summary Plan Description (Section 5: How to File a Claim).

When you submit a claim on this basis, you may pay more because you did not notify the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost, less the required Copayment, Ancillary Charge and any deductible that applies.

To continue reading, go to right column on this page.

Benefits may not be available for the Prescription Drug Product after the documentation provided is reviewed.

Maintenance Medication Program

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications.

What You Must Pay

You are responsible for paying the applicable Copayment described in the *Benefit Information* table, in addition to any Ancillary Charge when Prescription Drug Products are obtained from a retail or mail service Network Pharmacy.

The Ancillary Charge applies when a covered Brand-name Prescription Drug Product is dispensed **at your request**, when a Generic substitute is available.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your Summary Plan Description:

- Copayments for Prescription Drug Products.
- Ancillary Charges.
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 and the contracted rate (Prescription Drug Cost) will not be available to you.

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Payment Information

Payment Term	Description	Amounts
Copayment	<p>Copayments for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost.</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none">• The applicable Copayment and Ancillary Charge or• The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. <p>For Prescription Drug Products at a mail service Network Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none">• The applicable Copayment or• The Prescription Drug Cost for that Prescription Drug Product. <p><i>See the Copayments stated in the Benefit Information table for amounts.</i></p>

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Benefit Information

Description of Pharmacy Type and Supply Limits

Your Copayment Amount

Prescription Drugs from a Retail Network Pharmacy

Benefits for outpatient Prescription Drug Products dispensed by a retail Network Pharmacy. The following supply limits apply:

- As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.
- A one cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copayment for each cycle supplied.
- For Insulin, as written by the provider, up to a consecutive 90-day supply of Insulin (for the payment of one Copayment), unless adjusted based on the drug manufacturer's packaging size. In order to receive the maximum Benefit, your provider should write your Prescription Order or Refill for the full 90 days.

15% of the Prescription Drug Cost, but not less than \$15 and not more than \$35 per Prescription Order or Refill for a **Generic Prescription Drug Product**.

25% of the Prescription Drug Cost, but not less than \$40 and not more than \$100 per Prescription Order or Refill for a **Preferred Brand Prescription Drug Product**.

30% of the Prescription Drug Cost, but not less than \$50 and not more than \$150 per Prescription Order or Refill for a **Brand-name Prescription Drug Product**.

In addition to the applicable Copayment described above, you are responsible for paying an Ancillary Charge (as defined in the Glossary) if a covered Brand-name Prescription Drug Product is dispensed **at your request**, when a Generic substitute is available.

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

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Prescription Drug Products from a Mail Service Network Pharmacy

Benefits for outpatient Prescription Drug Products dispensed by a mail service Network Pharmacy. The following supply limits apply:

- As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.

To receive the maximum Benefit, your provider must write your Prescription Order or Refill for the full 90 days.

For up to a 90 day supply, your Copayment is:

30% of the Prescription Drug Cost, but not less than \$40 and not more than \$90 per Prescription Order or Refill for a **Generic Prescription Drug Product**.

30% of the Prescription Drug Cost, but not less than \$100 and not more than \$250 per Prescription Order or Refill for a **Preferred Brand Prescription Drug Product**.

30% of the Prescription Drug Cost, but not less than \$125 and not more than \$375 per Prescription Order or Refill for a **Brand-name Prescription Drug Product**.

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

Prescription Drugs from a Non-Network Pharmacy (Retail or Mail Service)

Not Covered – no benefit will be paid.

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Benefits for Preventive Care Medication

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drugs*. You may determine whether a drug is a Preventive Care Medication through the internet at **www.myuhc.com** or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Section 2: What's Not Covered—Exclusions

Exclusions from coverage listed in the Summary Plan Description apply also to this Rider. In addition, the following exclusions apply:

1. Outpatient Prescription Drug Products obtained from a non-Network Pharmacy.
2. Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.
3. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
4. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental.
5. 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.
6. 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.
order or refill are assigned to Tier-3.
7. Prescription Drug Products dispensed for weight control or appetite suppression will be covered. Any other weight loss products are not covered..
8. A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting, excluding Depo Provera and other injectable drugs used for contraception.
9. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
10. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
11. Unit dose packaging of Prescription Drug Products.
12. Medications used for cosmetic purposes.
13. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, which are determined to not be a Covered Health Service.
14. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
15. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a prescription
16. Drugs available over-the-counter that do not require a

Prescription Order or Refill by federal or state law before being dispensed. Products that are comprised of components that are available in over-the-counter form or equivalent, except as required to treat symptoms related to viral infections causing the common cold.

17. Growth hormones which are not self-injectible.

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Section 3: Glossary of Defined Terms

This section:

- Defines the terms used throughout this Rider.
- Is not intended to describe Benefits.

Ancillary Charge - a charge, in addition to the Copayment, that you are required to pay for a covered Brand-name Prescription Drug Product which, **at your request**, is dispensed when a Generic is available. (Generic substitution availability is identified on the Maximum Allowable Cost ("MAC") List.) **For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the contracted reimbursement rate for Network Pharmacies for the Prescription Drug Product dispensed, and the MAC List price of the Generic substitute.**

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. A Prescription Drug Product is classified as a Brand-name based on available data resources, such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as a Brand-name by the Claims Administrator.

Generic - a Prescription Drug Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that the Claims

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Administrator identifies as a Generic product. Classification of a Prescription Drug Product as a Generic is determined by the Claims Administrator and not by the manufacturer or pharmacy. A Prescription Drug Product is classified as a Generic based on available data resources, such as Medi-Span, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy, or your Physician may not be classified as a Generic by the Claims Administrator.

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 Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

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

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

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Maintenance Medication – a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

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

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with the Claims Administrator or its designee to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Claims Administrator as a Network Pharmacy.

A Network Pharmacy can be either a retail or a mail service 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 FDA, and ending on the earlier of the following dates:

- The date it is approved by the Claims Administrator's Preferred Drug List Management Committee.
- December 31st of the following calendar year.

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Prescription Drug Cost - the rate the Claims Administrator has agreed to pay Network Pharmacies, including a dispensing fee and any sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug Product - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Plan, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - insulin syringes with needles;
 - blood testing strips - glucose;
 - urine testing strips - glucose;
 - ketone testing strips and tablets;
 - lancets and lancet devices;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets;
 - 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 permits issuing such a directive.

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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.

- End of Outpatient Prescription Drug Rider -

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Attachment I

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.

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Attachment II

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Group health Plans and health insurance issuers generally may not,

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under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Authorizations are required for longer lengths of stay.

Uniformed Services Employment and Reemployment Rights

As Federally Mandated

Definitions

Health Insurance means hospital, surgical, medical, dental, vision or prescription drug coverage provided under the plan. Health Coverage is subject to change as a result of open enrollments of plan modifications.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such ACT and any interpretive regulations or rulings).

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

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Uniformed services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Health Insurance: The employee will remain in his/her current company sponsored benefit program during active duty leave for up to 6 months at the commencement of military leave. Prior to the end of the 6th month, the employee should contact the Home Office Benefits Department for options in coordinating the health insurance benefits with the government benefits offered to those in active military duty. Returning full-time, active employees will be entitled to immediate reintroduction into the health insurance benefits without observing waiting periods.

Continuation of Group Health Insurance

1. For you and your eligible dependents: If Health Coverage ends because of your service in the uniformed services, you may elect to continue such Health Coverage, if required by USERRA, until the earlier of:

- a) the end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- b) 18 consecutive months after insurance ended.

2. To continue coverage, you or your dependent must pay the required premium, (including your former employer's share and any retroactive premium), unless your service in the uniformed service is for fewer than 31 days, in which event you must pay your share, if any, of the premium. The Plan Administrator will inform you or your dependent of procedures to pay premiums.

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3. End of Continuation. A covered person's continued Health Coverage will end at midnight on the earliest of:

- a) the day your former employer ceases to provide any group health plan to any employee;
- b) the day premium is due and unpaid;
- c) the day Health Coverage has been continued for the period of time provided in part 1 (a) or (b) above (or any longer period provided in the plan); or
- d) the day the master plan terminates.

Any Health Coverage for an eligible dependent will also end as provided in the 'Events Ending Your Coverage' provision of the plan.

4. Other Continuation Provisions. In the event Health Coverage is continued under any other continuation provision of the plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by your employer, then the premium you are required to pay may increase for the remainder of the period provided above.

Reemployment (following service in the uniformed services)

Following your discharge from such service, you may be eligible to apply for reemployment with your former employer in accord with USERRA. Such reemployment includes your right to elect reinstatement in any then existing health coverage provided by your employer.

Other Benefits

Your employer's leave of absence policy will determine your right to

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participate in any group life or other insurance.

After reemployment, credit will be given, if applicable, for the period of such service, if required to determine your benefit amounts, eligibility, or costs.

Important Notice

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by your employer or former employer, will apply.

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Attachment III

Summary Plan Description

Name of Plan: Peter Kiewit Sons', Inc. Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

Peter Kiewit Sons', Inc.
1550 Mike Fahey Street
Omaha, NE 68102
(402) 342-2052

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibility with respect to the Plan.

Entities related to the Plan Sponsor have adopted the Plan. A complete list of the employers sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is also available for examination by participants and beneficiaries.

Employer Identification Number (EIN): 91-1842817

IRS Plan Number: 506

Effective Date of SPD: January 1, 2021

Type of Plan: Group health care coverage plan

Name, Business address, and Business Telephone Number of Plan Administrator:

Peter Kiewit Sons', Inc.
1550 Mike Fahey Street
Omaha, NE 68102
(402) 342-2052

Claims Administrator: The company which provides certain administrative services for the Plan.

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services, including coordination of Benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. The Plan Sponsor also has selected a provider network established by United HealthCare Services, Inc. The named fiduciary of Plan is Peter Kiewit Sons', Inc., the Plan Sponsor.

Person designated as agent for service of legal process:

Service of process may be made upon:
Plan Administrator or Benefits Manager

Peter Kiewit Sons', Inc.
1550 Mike Fahey Street
Omaha, NE 68102
Service of process may also be made upon the Plan Sponsor's Legal Council.

Source of contributions under the Plan: Contributions to the Plan are made by Peter Kiewit Sons', Inc., its subsidiaries, affiliated companies and sponsored joint ventures. All Benefits under the Plan are paid from the general assets of the Plan Sponsor. Any required Employee contributions are used to partially reimburse the Plan Sponsor for Benefits under the Plan.

Method of calculating the amount of contribution: Employee-required contributions to the Plan Sponsor are the Employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required Employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to Employees.

Date of the end of the year for purposes of maintaining Plan's fiscal records: Plan year shall be a twelve month period ending December 31.

Determinations of Qualified Medical Child Support Orders.

The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Although the Plan Sponsor currently intends to continue the Benefits provided by this Plan, the Plan Sponsor reserves the right, at any time and for any reason or no reason at all, to change, amend, interpret, modify, withdraw or add Benefits or terminate this Plan or this Summary Plan Description, in whole or in part and in its sole discretion, without prior notice to or approval by Plan participants

and their beneficiaries. Any change or Amendment to or termination of the Plan, its Benefits or its terms and condition, in whole or in part, shall be made solely in a written Amendment (in the case of a change or Amendment) or in a written resolution (in the case of termination), whether prospective or retroactive, to the Plan. The Amendment or resolution is effective only when approved by the body or person to whom such authority is formally granted by the terms of the Plan. No person or entity has any authority to make any oral changes or Amendments to the Plan.

Benefits under the Plan are furnished in accordance with the Plan Description issued by the Plan Sponsor, including this Summary Plan Description.

Participant's rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the procedures to be followed in regard to denied claims or other complaints relating to the Plan are set forth in the body of this Summary Plan Description.

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

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 documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another group health Plan. You should be provided a Certificate of Creditable Coverage in writing, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a Certificate of Creditable Coverage by calling the number on the back of your ID card.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit Plan. The people who operate your Plan, 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of 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, 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 or a medical child support order, you may file suit in Federal court. If it should happen that Plan 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.

Assistance with Your Questions

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, United States Department of Labor listed in your

telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

GROUP VISION CARE PLAN

Please refer to the separate Vision Service Plan Evidence of Coverage document for Vision Care Benefits.

GROUP DENTAL CARE PLAN

Please refer to the separate Delta Dental of Nebraska Dental Benefit Plan Summary document for Dental Care Benefits.

LIFE INSURANCE COMPANY OF NORTH AMERICA

1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235

A Stock Insurance Company

BLANKET ACCIDENT POLICY

POLICYHOLDER: Peter Kiewit Sons', Inc.

POLICY NUMBER: ABL 980084

POLICY EFFECTIVE DATE: January 1, 2016

STATE OF ISSUE: Nebraska

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 A.M. on the Policy Effective Date shown above at the Policyholder's address. It will remain in effect for the duration of the Policy Term shown above if the premium is paid according to the agreed terms. This Policy terminates at 12:00 A.M., on the day following the last day of the Policy Term unless the Policyholder and We agreed to continue coverage under this Policy for an additional Policy Term. The laws of the State of Issue shown above govern this Policy.

We and the Policyholder agree to all of the terms of this Policy.

THIS IS A LIMITED POLICY

IT PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY

IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS

PLEASE READ IT CAREFULLY.

SCHEDULE OF BENEFITS

CONDITIONS OF COVERAGE

The benefits provided by this Policy will be paid, subject to applicable conditions, limitations and exclusions, under the following coverages.

Bomb Scare, Search or Explosion Coverage

Business Travel Coverage

Personal Deviations covered

Yes

Personal Deviation takes place

during, or within 14 days before or after, covered

Business Travel

Maximum Length of Personal Deviation

14 days

Exposure and Disappearance Coverage

Owned Aircraft Coverage

Pilot Coverage

Relocation Coverage

Personal Deviations covered	Yes
Personal Deviation takes place	within 14 days during, before or after a Relocation Trip
Maximum Length of Personal Deviation	14 days

War Risk Coverage**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

Principal Sum:	\$200,000
Loss must occur within:	365 days of the Covered Accident

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Unilateral Paraplegia	25% of the Principal Sum
Coma	5% of the Principal Sum
Monthly Benefit	5% of the Principal Sum
Number of Monthly Benefits	11
When Payable	At the end of each month during which the Covered Person remains comatose
Lump Sum Benefit	100% of the Principal Sum
Sum When Payable	Beginning of the 12 th month
Loss of One Hand or Foot	50% of the Principal Sum

Loss of Sight in One Eye	50% of the Principal Sum
Covered Loss	Benefit
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum Severance and Reattachment of
One Hand or Foot	50% of the Principal Sum Loss of Thumb and Index Finger of the Same Hand
of the Principal Sum	25%
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

Aggregate Limit of Indemnity

Applies to:	Amount
War Risk Coverage	\$2,500,000

Not more than the Aggregate Limit of Indemnity specified above will be paid for all Covered Losses suffered by all Covered Persons insured under this Accidental Death Benefit as the result of any one Covered Accident that occurs under one of the Conditions of Coverage, as specified above. If this amount does not allow all Covered Persons to be paid the amounts this Policy otherwise provides, the amount paid will be the proportion of the Covered Person's loss to the total of all losses, multiplied by the Aggregate Limit of Indemnity.

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Any benefits payable under these Additional Accident Benefits shown below are in addition to any other Accidental Death and Dismemberment benefits payable.

BEREAVEMENT AND TRAUMA COUNSELING BENEFIT

Benefit Amount	\$250 per session
Maximum Number of Sessions	10 sessions
Maximum Benefit Per Covered Accident	\$2,500

BURIAL AND CREMATION BENEFIT

\$10,000

CHILD CARE CENTER BENEFIT

Benefit Amount	3% of the Employee's Principal Sum
subject to a maximum of \$3,000 per year	
Maximum Benefit Period 5 years	
or until the child turns 13 for each surviving Dependent Child	

Default Benefit \$1,000

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

Benefit 10% of the Principal Sum subject to a maximum of \$10,000

REHABILITATION BENEFIT

Benefit per Covered Accident 10% of the Principal Sum, subject to a maximum of \$10,000

SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit \$10,000
Airbag Benefit 5% of the Principal Sum subject to a maximum of \$10,000
Default Benefit \$1,000

SPECIAL EDUCATION BENEFIT

Surviving Dependent Child Benefit 3% of the Principal Sum subject to a Maximum Benefit of \$3,000

Surviving Spouse Benefit 3% of the Principal Sum subject to a Maximum Benefit of \$3,000

Maximum Number of Annual Payments
For Each Surviving Dependent Child 4
For Surviving Spouse 3
Default Benefit \$1,000

GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Aircraft A vehicle which:
1. has a valid certificate of airworthiness; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Covered Accident A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. occurs under one of the Conditions of Coverage specified in the *Schedule of Benefits*;
3. is not contributed to by disease, Sickness, or mental or bodily infirmity;
4. is not otherwise excluded under the terms of this Policy.

Covered Injury Any bodily harm that results, directly and independently of all other causes, from a Covered Accident.

Covered Person An Eligible Person, as defined in the *Schedule of Benefits*, for whom required premium has been paid when due and for whom coverage under this Policy remains in force.

Employee An Employee of the Employer who is in one of the Covered Classes.

Employer The Policyholder and any affiliates, subsidiaries or divisions shown in the *Schedule of Affiliates* covered under this Policy on its effective date or a later date agreed to by Us.

He, His, Him Refers to any individual, male or female.

Hospital An institution that meets all of the following:

1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:

1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.

Nurse A licensed graduate registered nurse (R.N.) or a licensed practical nurse (L.P.N.) who is not:

1. the Covered Person;
2. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;

3. a person living in the Covered Person's household; or
4. a person employed or retained by the Policyholder.

Personal Deviation An activity which:

1. is neither reasonably related to or incidental to the purpose of travel for which coverage is provided by this Policy; and
2. the Covered Person performs before, during or after covered travel.

When coverage is provided during a Personal Deviation, the time period covered is shown in the *Conditions of Coverage* section of the *Schedule of Benefits*.

Physician A United States-licensed health care provider practicing in the United States within the scope of his license and rendering care and treatment to the Covered Person that is appropriate for the condition and locality, and who is not:

1. the Covered Person;
2. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
3. a person living in the Covered Person's household;
4. a person employed or retained by the Policyholder; or
5. a person providing homeopathic, aroma-therapeutic, or herbal therapeutic services.

Policyholder The entity, named on this Policy's face page, to which We issue this Policy.

Private Passenger Automobile A validly registered, four wheel private passenger car, including Policyholder-owned cars, campers, motor homes, station wagons, sport utility vehicles, pick-up trucks and van-type cars that are not licensed commercially or being used for commercial purposes. Any vehicle being used as a taxicab, bus, or other public conveyance will not be considered a Private Passenger Automobile.

Sickness A physical or mental illness, including pregnancy.

We, Us, Our Life Insurance Company of North America

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS

Policy Effective Date The Insurance Company agrees to provide Accident Insurance Benefits described in this Policy in consideration of the Policyholder's application and payment of the Initial Premium when due. Insurance begins on the Policy Effective Date shown on this Policy's first page.

Effective Date for Newly-Acquired Affiliates Insurance becomes effective for any newly-acquired affiliate of the Policyholder on the date it is acquired, if: We have been notified in writing within the time period specified in the *Schedule of Affiliates* and have agreed to provide insurance, and additional premium has been paid when due. If We are not notified within the required time period, insurance for the affiliate will become effective on the date we agree in writing to insure it and receive any additional premium due. Individuals who are employees of an affiliate on its effective date of insurance under this Policy will be eligible for insurance on that date.

Eligibility A person is eligible for insurance under this Policy when he meets the definition of Eligible Person shown in the *Schedule of Benefits*. An Eligible Person may be insured under only one Covered Class, even though he may be eligible under more than one Covered Class.

Effective Date for Individuals Insurance becomes effective for the Eligible Person on the later of the following dates:

1. the Policy Effective Date;
2. the date the person becomes eligible.

In no event will insurance for the Eligible Person become effective before the Policy Effective Date.

Effective Date of Changes Any increase or decrease in the amount of insurance for the Covered Person resulting from:

1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class will take effect on the date of such change.

Termination of Insurance Insurance for the Covered Person will end on the earliest of:

1. the date the person is no longer in an Eligible Class; and
2. the date the person enters full time active duty in any Armed Forces. We will refund any premium paid for any period of active duty when We receive proof of active duty. Active duty does not include Reserve or National Guard duty for training; and
3. the end of the period for which the last premium is paid; and
4. the date this Policy ends.

Termination does not affect a claim for a Covered Loss due to a Covered Accident that occurs before the termination date. However, in no instance will benefits extend beyond the earliest of:

1. the end of the Benefit Period; and
2. the date benefits equal to any applicable Benefit Limit, as shown in the *Schedule of Benefits*, have been paid; and

3. the date benefits equal to any applicable Policy Aggregate Maximum, as shown in the *Schedule of Benefits*, have been paid.

COMMON EXCLUSIONS

In addition to any benefit-specific exclusion, benefits will not be paid for any Covered Injury or Covered Loss which directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Conditions of Coverages* and *Description of Indemnity Benefits* sections.

1. Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. declared or undeclared war or act of war;
5. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
 - a. except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
 - b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
 - c. being used for:
 - i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
 - ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
 - d. an ultra-light or glider;
 - e. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
 - f. being used for the purpose of parachuting or skydiving;
 - g. designed for flight above or beyond the earth's atmosphere;
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, including exposure, whether or not accidental, to viral, bacterial or chemical agents except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
7. travel in any Aircraft owned, leased or controlled by the Policyholder, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be 'controlled' by the Policyholder if the Aircraft may be used as the Policyholder wishes for more than 10 straight days, or more than 15 days in any year;

8. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred.

In addition, benefits will not be paid for services or treatment rendered by any person who is:

1. employed or retained by the Policyholder;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of either the Covered Person or the Covered Person's spouse;
4. the Covered Person.

OTHER BENEFITS UNDER PETER KIEWIT SONS', INC.

HEALTH & WELFARE PLAN

Group Life, Individual Supplemental Life and Supplemental Dependent Life. (FLX 961441 And AD&D Group and Supplemental Insurance (OK 961535) Underwritten by CIGNA Insurance Company.

Group Short Term Disability (GRH-71077) Underwritten by Hartford Life and Accident Insurance Company.

Group Long Term Disability - (GLT-044310) Underwritten by Hartford Life and Accident Insurance Company.

For additional information on the benefit plans listed above please refer to the separate booklets or contact the Home Office Benefits Department 1-855-329-7907.

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