Summary Plan Description

The United States Postal Service

Non-Career Employee Health Benefits Plan

Effective: January 2015
Group Number: 755011

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SECTION 1 - WELCOME

Quick Reference Box

- Member services and claim inquiries (888) 496-6959;
- Claims submittal address for outpatient Prescription Drug Benefits claims: OptumRX, P.O. Box 29044, Hot Springs, AR 71903;
- Claims submittal address for medical claims: UnitedHealthcare - Claims, P.O. Box 30884, Salt Lake City, UT 84130-0884; and
- Online assistance: **www.myuhc.com**.
- TTY: 1-877-492-7341;

The United States Postal Service is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members. It includes a summary of:

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

IMPORTANT
The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 15, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, Substance Use Disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

The United States Postal Service intends to continue this Plan, but reserves the right to terminate or amend the Plan at any time consistent with its responsibilities under the law. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

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

Please read this SPD thoroughly to learn how the Plan works. If you have questions contact the Human Resources Shared Service Center (HRSSC) at 1-877-477-3273 #5, TTY: 1-877-492-7341, or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then, keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments at https://liteblue.usps.gov (look for the section on Non-Career employee benefits) or request printed copies by contacting the HRSSC at 1-877-477-3273 #5, Or TTY: 1-877-492-7341.
- Capitalized words in the SPD have special meanings and are defined in Section 15, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 15, *Glossary*.
- The United States Postal Service is also referred to as Company and the USPS.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who is eligible for coverage under the Plan;
- Which Family Members are Eligible;
- Ineligible Family Members;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Qualifying Life and Permitting Events Change Matrix.

Eligibility

To be eligible for USPS Non-Career Employee Health Benefits (NCEHB) Plan enrollment, non-career employees (NCEs) must meet one of these requirements:

- Be a City Carrier Assistant (CCA) or a Mail Handler Assistant (MHA), OR
- Be a rural carrier or non-bargaining non-career employee (NCE); and

also meet the Patient Protection and Affordable Care Act (PPACA) definition of a full-time employee by averaging 30 paid hours per week over a measurement period.

The measurement periods used to determine full-time status under (2) above are:

- The Standard Measurement Period test is used for ongoing NCEs to determine eligibility for coverage before Open Season each year. This measurement period is twelve (12) months, as follows:
  - Start: Day 1 of the Pay Period (PP) starting on or after October 10 in the calendar year before the Open Season.
  - End: Day 14, 26 PPs later, in the calendar year of the Open Season.
- The Test for a Reasonable Expectation to Average 30 Hours is a short initial test that will be used for newly hired NCEs to determine if they are expected to be full-time employees as defined by PPACA. This measurement period is 3 PPs, as follows:
  - Start: Day 1 of the PP on or after the entered on duty (EOD) date.
  - End: Day 14, 3 PPs later.
- The Variable Hours New Hire Measurement Period is a longer test for newly hired NCEs who do not meet the Test for a Reasonable Expectation to Average 30 Hours. This Variable Hours New Hire Measurement Period is 24 PPs, as follows:
  - Start: Day 1 of the PP on or after the EOD date.
  - End: Day 14, 24 PPs later.

Once enrolled, there is a Stability Period during which NCEs who qualify based on their full-time status will remain eligible for coverage even if their hours drop below 30 hours per week. For NCEs qualifying under the Standard Measurement Period test, the Stability Period will be the plan year that begins after the Open Season. For NCEs qualifying based on one of the two newly hired NCE tests, the Stability Period will be the remainder of the plan year in which they qualified for coverage plus the following plan year.

When you first become eligible for the plan, you will be sent a letter in the mail informing you of your eligibility for the plan and enrollment deadline. CCAs and MHAs automatically qualify as eligible and therefore will not receive a notification letter.

Note: NCEs who are eligible based on their full-time status will have their hours tested each year during the Standard Measurement Period to determine their eligibility for the following plan year.

Which Family Members Are Eligible?

For consistency, since NCEs may be simultaneously eligible for the USPS NCEHB Plan and the Federal Employees Health Benefits (FEHB) Program, the USPS NCEHB Plan will follow FEHB's definition for eligible family members. Your family members who are eligible and covered under a Self and Family enrollment includes:

- Your spouse (including a valid common law marriage).
- Your children under age 26, including recognized natural children, legally adopted children, and stepchildren.
- Foster children are included if they meet certain requirements.
- A child age 26 or over who is incapable of self-support because of a mental or physical disability that existed before age 26 is also an eligible family member.

Contact the Human Resources Shared Service Center (HRSSC) for additional information in determining whether a child is a covered family member; the HRSSC will look at the child's relationship to you as an enrollee.

Note: The definition of spouse includes a same-sex spouse whom you have legally married in a jurisdiction that permitted same-sex marriages, regardless of where you currently live or work.

Ineligible Family Members

Even though the following family members may live with and/or be dependent upon an enrollee, they are NOT ELIGIBLE for coverage under a Self and Family enrollment:

- Parents and other relatives; and
- Former spouses.

Dual Enrollment

Dual enrollment is not permitted and if you have dual enrollment you must take action to end it. Dual enrollment occurs when you are covered under more than one USPS NCEHB Plan enrollment. For example, you are not allowed to be covered under your spouse's USPS NCEHB Plan Self and Family enrollment and also have your own Self Only enrollment. Dual enrollment is allowed in unusual circumstances when you or an eligible family member would otherwise not be able to have coverage. For example, if you are under age 26 and your parent is an eligible NCE with a Self and Family enrollment, that enrollment covers you and your other parent as eligible dependents. If you have your own children, you would also need your own Self and Family enrollment to cover your own children. If you have questions regarding dual enrollment please contact the HRSSC.

As a non-career employee with the Postal Service, you also may be eligible to enroll in FEHB if you meet OPM requirements, as explained in RI 70-8PS, Guide to Benefits for Certain Temporary (Non-Career) United States Postal Service Employees. Note that you are not allowed to simultaneously have a USPS NCEHB Plan enrollment and an FEHB enrollment. However, you are allowed to have a USPS NCEHB Plan enrollment and also be covered as a family member under someone else's FEHB enrollment. And you are allowed to have a USPS NCEHB Plan Self and Family enrollment that covers a family member who has his or her own FEHB enrollment.

Requirement to Keep Information about Your Dependents Current

If you enroll in Self and Family coverage, you will need to enter complete information in PostalEASE during the enrollment process. In addition, it is your responsibility and your obligation to contact the HRSSC and advise them of any changes in the status of your covered dependents during your coverage period that may affect their eligibility for insurance coverage. If you are not certain about any dependent changes, it is best to contact the HRSSC. Also, if you add a dependent to your Self and Family coverage, you must contact the HRSSC promptly and provide the appropriate documentation so that coverage is available to your new dependent.

Cost of Coverage

You and the United States Postal Service share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll. Refer to the Guide to USPS Non-Career Employee Health Benefits Plan for your current contribution amount.

NCEs who enroll in the USPS NCEHB Plan may elect to have premium costs withheld from pay on a pre-tax basis. See the section below regarding this option.

Pre-Tax Payment Of Premium Contributions

Premium payment for non-career employees is automatically withheld on an after-tax basis. However, the Postal Service has established the pre-tax payment of health insurance premium contributions as a tax-saving benefit feature for its employees and you may elect it during Open Season, when you are hired, or if you have a qualifying life event.

Pre-Tax Withholding

There are two possible disadvantages of paying your premiums with pre-tax money that you should balance against the tax savings you receive. First, when you retire, if you begin to collect Social Security (normally this occurs at age 62 at the earliest), you may receive a slightly lower Social Security benefit. Paying your premiums with pre-tax money reduces the earnings reported to the Social Security Administration. (Medicare is not affected.) Second, there are restrictions on reducing or canceling your coverage outside Open Season that apply if you pay your premium contributions with pre-tax money. These are explained in the section "Reducing Coverage" below.

If you want to pay your premiums with pre-tax money, you must request PS 3119 Application to Elect or Waive Pretax USPS Non-Career Employee Health Benefits Plan Premium from the HRSSC by calling 1-877-477-3273, option 5; TTY 1-866-260-7507. During Open Season, complete the form and return it to the HRSSC prior to the close of Open Season. If this is your initial opportunity to enroll in the USPS NCEHB Plan as a newly eligible NCE, and you wish to elect pre-tax payments, you have 60 days from your eligibility date to submit your election to the HRSSC. You may also make such an election when you have a qualifying life event as shown in the Qualifying Life and Permitting Events Change Matrix found in this SPD. Refer to the column labeled "Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums." You must also satisfy the time limits shown in the column labeled "Time Limits in Which Change May Be Permitted." If you previously submitted an election to participate in pre-tax payments and you want to begin paying your premiums with after-tax money again, you may submit a new PS 3119 Application to Elect or Waive Pretax USPS Non-Career Employee Health Benefits Plan Premium to restore after-tax payment of your premium contributions. You may change the method of payment from pretax to after-tax, or the reverse only during the annual Open Season or following a qualifying life event and within the time limits shown in the Qualifying Life Events Matrix.

Reducing Coverage

When you elect to have your premium contributions withheld on a pre-tax basis, certain Internal Revenue Service (IRS) guidelines affect your ability to change coverage. You may elect to reduce your coverage, that is, to cancel your NCEHB Plan enrollment, or to go from Self and Family to Self Only coverage, only during Open Season, unless you have a qualifying life event. These are shown in the Qualifying Life and Permitting Events Change Matrix in this SPD. Refer to the column labeled "Permitted Enrollment Change" and the header "Cancel or Change to Self Only." You also must satisfy the time limits shown in the column labeled "Time Limits in Which Change May Be Permitted."

If you elected to have your premium contributions withheld on a pre-tax basis, then reducing your coverage outside of Open Season must be in keeping with, or on account of, your qualifying life event. For example, if you have a new baby, you usually would not change from Self and Family to a Self Only enrollment, or cancel coverage. To reduce your coverage outside of Open Season, submit a PS 3117 PostalEASE USPS Non-Career Employee Health Benefits Plan Worksheet to the HRSSC within the time limits shown in the column labeled "Time Limits in Which Change May be Permitted" in the Qualifying Life and Permitting Events Change Matrix in this SPD. You must provide any supporting documentation requested by the HRSSC. The effective date of a change from Self and

Family to Self Only will be the first day of the first full pay period after your Worksheet is received by the HRSSC. The effective date of a cancellation will be the last day of the pay period in which your Worksheet is received by the HRSSC. If you are the only person left in your Self and Family enrollment as a result of a qualifying life event in marital or family status, make sure you follow these instructions to reduce your coverage to Self Only. Otherwise, your Self and Family enrollment will continue until another event (that is, a qualifying life event or Open Season) occurs that allows you to elect to reduce coverage, which means you are paying extra for coverage that you cannot use.

Your Right To More Information

There is also a legal plan document containing the full legal plan provisions regarding the pre-tax payment of health insurance premium contributions, which you may arrange to view by writing to:

PRETAX PAYMENT OF HEALTH INSURANCE PREMIUMS
PLAN ADMINISTRATOR
475 L'ENFANT PLAZA SW ROOM 9670
WASHINGTON, D.C. 20260-4101

Opportunities to Enroll

All eligible NCEs may enroll (begin coverage) in the USPS Non-Career Employee Health Benefits Plan as follows:

- During the Open Season that begins each November.
- When certain qualifying life events occur. An election must be made within the time limits as specified in the Qualifying Life and Permitting Events Change Matrix found in this SPD.
- New Hires – CCAs and MHAs may elect USPS Non-Career Employee Health Benefits Plan coverage within 60 days of the date they were hired. Other non-career employee new hires may elect coverage within 60 days of the date they become eligible for coverage. Reappointment – Eligible NCEs do not have an opportunity to elect coverage if they are reappointed after the standard 5-day break in service between appointments, since plan enrollment continues during a 5-day break. In the unlikely event that an eligible NCE is reappointed after a break in service of 6 days or more and less than 13 weeks, then the NCE does have an opportunity to elect coverage within 60 days of the reappointment date. If a non-career employee is reappointed after a break of more than 13 weeks, then the NCE will be treated as a new hire.

Opportunities to Change or Cancel Your Enrollment

Once you have enrolled, you have an opportunity to change your enrollment (from Self Only to Self and Family or vice versa) or cancel your enrollment as follows:

- During a subsequent Open Season (Open Seasons begin each November and last approximately 4 weeks).
- Other than Open Season, you may only change your enrollment from Self Only to Self and Family when certain qualifying life events occur. These elections must be made

within the time limits as specified in the Qualifying Life Events Matrix found in this SPD.

- For non-career employees premiums are defaulted to being paid on an after-tax basis. Therefore, unless you elect the pre-tax payment of premiums, your premiums will be paid on an after-tax basis, and you can change your enrollment from Self and Family to Self Only or cancel your enrollment at any time—you do not have to have a qualifying life event.
- If you elect the pre-tax payment of premiums, you may only change from Self and Family to Self Only or cancel your enrollment as specified in the Qualifying Life and Permitting Events Change Matrix on found in this SPD.

How to Enroll, Change or Cancel Your Enrollment

The United States Postal Service uses PostalEASE to enter USPS Non-Career Employee Health Benefits Plan Open Season enrollments and changes and New Hire enrollments. All the information you need for using PostalEASE is found on the PS 3117 PostalEASE USPS Non-Career Employee Health Benefits Plan Worksheet, which you use to prepare to:

- Enroll
- Change Enrollment
- Cancel Enrollment
- Review or change your pending Open Season transaction
- Review or update your dependent information
- Review your current enrollment information
- Receive a copy of a health benefits election that was processed using PostalEASE

Please do not wait until late in the Open Season to enter your choice via PostalEASE.

All Open Season Self Only enrollments, changes to Self Only coverage, and cancellations, should be entered as employee self-service transactions using PostalEASE. Since dependent information is not required for Self Only coverage, such transactions are simple. Most Self and Family enrollments can also be completed as employee self-service transactions, although they require additional information about your eligible family members. The easiest way to do this is via the PostalEASE Employee Web, which is available through the LiteBlue page, Blue page, or on a kiosk. PostalEASE provides the enrollment date, processing date, and effective date when you complete your transaction. You may delete or change a pending transaction until it is processed. To prepare, first complete PS 3117 PostalEASE USPS Non-Career Employee Health Benefits Plan Worksheet and follow the instructions carefully.

Use PostalEASE within 60 days of your eligibility date. If you do not enroll within 60 days, you will need to wait until the next annual Open Season to make your benefit elections.

Each year during annual Open Season, you have the opportunity to review and change your medical election. Any changes you make during Open Season will become effective the first day of the first full pay period that begins in January.

Important
If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact the HRSSC within 60 days of the event. Otherwise, you will need to wait until the next annual Open Season to change your elections. See the Qualifying Event and Permitting Events Change Matrix that follows.

When Will My Coverage Begin and When Will an Enrollment Change Take Effect?

For consistency the USPS Non-Career Employee Health Benefits Plan will follow FEHB's coverage effective dates. FEHB's coverage effective dates are as follows:

- Open Season – An enrollment or change in enrollment is effective on the first day of the first full pay period that begins in January.
- New Hire or Qualifying Life Event – An enrollment or a change in enrollment is effective on the first day of the first pay period that begins after the HRSSC receives your valid enrollment.
- When you add an eligible dependent the coverage effective date is as follows:

Employee adds a dependent to a Self and Family enrollment

If you have a Self and Family enrollment, a newly eligible family member such as a spouse or a newborn will be automatically covered from the date he/she becomes a family member. When you do not list an eligible family member (either by providing dependent information in PostalEASE during Open Season or as a newly hired employee, or otherwise by notifying the HRSSC) that person will not be eligible for coverage until any appropriate documentation has been provided and the eligible family member is enrolled. Coverage will be effective as of the date the dependent became eligible (for example, if a newborn child is enrolled a week after childbirth, coverage is effective as of the date of the child's birth).

- Foster Child—the effective date of a foster child's coverage as a family member is the first day of the pay period in which the HRSSC receives all of the properly completed documents that establish the eligibility of the child as a foster child. When the foster child's mother is an eligible family member under the employee's enrollment, the employee may request that the effective date be the first day of the pay period in which the child was born.
- Child Incapable of Self-Support—if an employee submits medical certification for a child after a previous certification has expired, or after a child has reached age 26, the HRSSC must determine whether the disability existed before age 26. If the HRSSC determines that it did, and the employee continuously had Self and Family coverage, the child is considered to have been continuously covered as a child incapable of self-support since age 26.

Employee changes from a Self Only to a Self and Family enrollment

- Spouse—if an employee wants to provide immediate coverage for a new spouse, the employee may submit a PS 3117 PostalEASE USPS Non-Career Employee Health Benefits Plan Worksheet to the HRSSC up to 31 days before the anticipated date of marriage. If the effective date of the enrollment change to Self and Family coverage is before the marriage, the new spouse does not become eligible for coverage until the actual day of marriage. If the effective date of the enrollment change is after the marriage, the new spouse does not become eligible for coverage until the effective date of the Self and Family enrollment.
- Child—if an employee changes from Self Only to Self and Family due to the birth or addition of a child, the effective date of the enrollment change will be the first day of the pay period in which the child becomes a family member.
- Foster Child--the effective date of a foster child's coverage as a family member is the first day of the pay period in which the HRSSC receives all of the properly completed documents that establish the eligibility of the child as a foster child. When the foster child's mother is an eligible family member under the employee's enrollment, the employee may request that the effective date be the first day of the pay period in which the child was born.
- Child Incapable of Self-Support—if an employee submits medical certification for a child after a previous certification has expired, or after a child has reached age 26, the HRSSC must determine whether the disability existed before age 26. If the HRSSC determines that it did, the child is considered to have been continuously covered as a child incapable of self-support since age 26, or since the effective date of Self and Family coverage, whichever is later. (However, note that the child could have been covered without a certification until age 26 as early as the effective date of Self and Family 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, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible.

Qualifying Life And Permitting Events Change Matrix

For consistency, since NCEs may be simultaneously eligible for the USPS NCEHB Plan and FEHB, the USPS NCEHB Plan Qualifying Life and Permitting Events Change Matrix is similar to the Table of Permissible Changes for FEHB. Benefit events are used to define and record an occurrence in an NCE's life or job that relates to benefits, or an event in the USPS NCEHB Plan's administration in benefit terms. Benefit events may have an effect on an NCE's eligibility and/or his or her dependent's eligibility, coverage, or contribution deduction amount. Benefit events can be classified as employee driven changes, employer

driven changes, or system generated changes. When an NCE experiences a qualifying life event (QLE) as described in the Qualifying Life and Permitting Events Change Matrix below, changes to the NCE's USPS NCEHB Plan coverage (including a change to Self Only and cancellation) and pre-tax payment of premium contribution elections may be permitted so long as they are because of and consistent with the QLEs. Be aware that time limits apply for requesting changes.

Note: An NCE who is enrolled in FEHB and has a Qualifying Life Event may then have an opportunity to elect coverage under the USPS NCEHB Plan.

For non-career employees premiums are defaulted to be paid on an after-tax basis. Therefore, unless you elect the pre-tax payment of premiums, your premiums will be paid on an after-tax basis, and you can change your enrollment from Self and Family to Self Only or cancel your enrollment at any time—you do not have to have a qualifying life event.

If you elect the pre-tax payment of premiums, you may only change from Self and Family to Self Only or cancel your enrollment in accordance with the chart below.

If you have questions, contact the HRSSC on 1-877-477-3273, option 5; TTY 1-866-260-7507.

	Qualifying Life Events (QLEs) That May Permit Change in Enrollment or **Election of Pre-Tax vs. After-Tax Payment of Premiums**	**Permitted Enrollment Change**			**Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums**		**Time Limits in Which Change May Be Permitted**
Event Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with HRSSC**
1A	Initial Opportunity to Enroll - New employee	Yes	N/A	N/A	Yes	Automatic unless you elect pre-tax payment of premiums	Within 60 days after becoming eligible *PostalEASE* Employee Self-Service is preferred way for you to make your election, not HRSSC
1B	Open Season	Yes	Yes	Yes	Yes	Yes	As announced by USPS *PostalEASE* Employee Self-Service is preferred way for you to make your election, not HRSSC
1C1	Birth, adoption, acquiring foster child or stepchild	Yes	Yes	Yes	Yes	Yes	May enroll or change beginning 31 days before the event and within 60 days after the change in family status
1C2	Death of spouse	Yes	Yes	Yes	Yes	Yes	May enroll or change within 60 days after the change in family status
1C3	Death of an eligible dependent child	Yes	Yes	Yes	Yes	Yes	May enroll or change within 60 days after the change in family status
1C4	Dependent child now ineligible, for example: Child reaches age 26 Disabled child	Yes	Yes	Yes	Yes	Yes	May enroll or change beginning 31 days before the event and within 60 days after the change in family

	Qualifying Life Events (QLEs) That May Permit Change in Enrollment or **Election of Pre-Tax vs. After-Tax Payment of Premiums**	**Permitted Enrollment Change**			**Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums**		**Time Limits in Which Change May Be Permitted**
Event Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with HRSSC**
	becomes capable of self-support						status
1C5	Marriage	Yes	Yes	Yes	Yes	Yes	May enroll or change beginning 31 days before the event and within 60 days after the change in family status
1C6	Divorce or annulment	Yes	Yes	Yes	Yes	Yes	May enroll or change beginning 31 days before the event and within 60 days after the change in family status
1C7	QMSCO Add	Yes	Yes	Yes	Yes	Yes	May enroll or change beginning 31 days before the event and within 60 days after the change in family status
1C8	QMSCO Revoked	Yes	Yes	Yes	Yes	Yes	May enroll or change beginning 31 days before the event and within 60 days after the change in family status
1D	Any change in employee's employment status that could result to entitlement to coverage, for example: • Reemployment after a break in service of more than 5 days	Yes	N/A	N/A	Yes	Automatic unless waived	Within 60 days after employment status change

	Qualifying Life Events (QLEs) That May Permit Change in Enrollment or **Election of Pre-Tax vs. After-Tax Payment of Premiums**	**Permitted Enrollment Change**			**Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums**		**Time Limits in Which Change May Be Permitted**
Event Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with HRSSC**
	• Return to pay status from nonpay status, or return to receiving pay sufficient to cover premium withholdings, if coverage terminated (If coverage did not terminate, see 1G)						
1E	Any change in employee's employment status that could affect the cost of insurance, including: • Change from temporary appointment with eligibility for coverage under 5 USC 8906a to appointment that permits receipt of government contribution • Change from full time to part time career or the reverse	Yes	Yes	Yes	Yes	Yes	Within 60 days after employment status change
1F	Employee restored to civilian position after serving in uniformed services[2]	Yes	Yes	Yes	Yes	Yes	Within 60 days after return to civilian position
1G	Employee, spouse	No	No	Yes	Yes	Yes	Within 60 days after

	Qualifying Life Events (QLEs) That May Permit Change in Enrollment or **Election of Pre-Tax vs. After-Tax Payment of Premiums**	**Permitted Enrollment Change**			**Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums**		**Time Limits in Which Change May Be Permitted**
Event Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with HRSSC**
	or dependent: • Begins nonpay status or insufficient pay [3] or • Ends nonpay status or insufficient pay if coverage continued • (If employee's coverage terminated, see 1D) • (If spouse's or dependent's coverage terminated, see 1M)						employment status change
1H	Salary of temporary employee insufficient to make withholdings for plan	N/A	No	Yes	Yes	Yes	Within 60 days after receiving notice from employing office
1I	Employee (or covered family member) enrolled in FEHB health maintenance organization (HMO) moves or becomes employed outside the geographic area from which the FEHB carrier accepts	N/A	Yes	N/A *(see 1M)*	No *(see 1M)*	No *(see 1M)*	Upon notifying HRSSC of move

	Qualifying Life Events (QLEs) That May Permit Change in Enrollment or **Election of Pre-Tax vs. After-Tax Payment of Premiums**	**Permitted Enrollment Change**			**Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums**		**Time Limits in Which Change May Be Permitted**
Event Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with HRSSC**
	enrollments or, if already outside the area, moves further from this area. [4]						
1J	Transfer from post of duty within a state of the United States or the District of Columbia to post of duty outside a State of the United States or District of Columbia, or reverse.	Yes	Yes	Yes	Yes	Yes	Within 60 days after arriving at new post. *Employees may enroll or change beginning 31 days before leaving the old post of duty.*
1K	Separation from employment when the employee or employee's spouse is pregnant.	Yes	Yes	N/A	N/A	N/A	During NCE's final pay period
1L	Employee becomes entitled to Medicare and wants to change to another plan or option. [5]	No	No	N/A (see 1P)	N/A (see 1P)	N/A (see 1P)	Any time beginning on the 30th day before becoming eligible for Medicare.
1M	Employee or eligible family member loses coverage under FEHB or another group insurance plan including the following: • Loss of coverage under another	Yes	Yes	Yes	Yes	Yes	Within 60 days after loss of coverage. *Employees may enroll or change beginning 31 days before the event.*

	Qualifying Life Events (QLEs) That May Permit Change in Enrollment or **Election of Pre-Tax vs. After-Tax Payment of Premiums**	**Permitted Enrollment Change**			**Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums**		**Time Limits in Which Change May Be Permitted**
Event Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with HRSSC**
	FEHB enrollment due to termination, cancellation, or change to Self Only of the covering enrollment • Loss of coverage due to termination of membership in employee organization sponsoring the FEHB plan [6] • Loss of coverage under another federally-sponsored health benefits program, including: TRICARE, Medicare, Indian Health Service • Loss of coverage under Medicaid or similar State-sponsored program of medical assistance for the needy • Loss of coverage under a non-Federal health plan, including foreign, state or local government, private sector • Loss of coverage due to change in						

	Qualifying Life Events (QLEs) That May Permit Change in Enrollment or **Election of Pre-Tax vs. After-Tax Payment of Premiums**	**Permitted Enrollment Change**			**Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums**		**Time Limits in Which Change May Be Permitted**
Event Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with HRSSC**
	worksite or residence (Employees in an FEHB HMO, also see 1I)						
1N	Loss of coverage under a non-Federal group health plan because an employee moves out of the commuting area to accept another position and the employee's non-Federally employed spouse terminates employment to accompany the employee.	Yes	Yes	Yes	Yes	Yes	From 31 days before the employee leaves the commuting area to 180 days after arriving in the new commuting area.
1O	Employee or eligible family member loses coverage due to discontinuation in whole or part of FEHB plan [7]	Yes	Yes	Yes	Yes	Yes	During Open Season, unless OPM sets a different time
1P	Enrolled employee or eligible family member gains coverage under FEHB or another group insurance plan, including the following: • Medicare (Employees who	No	No	Yes	Yes	Yes	Within 60 days after QLE

	Qualifying Life Events (QLEs) That May Permit Change in Enrollment or **Election of Pre-Tax vs. After-Tax Payment of Premiums**	**Permitted Enrollment Change**			**Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums**		**Time Limits in Which Change May Be Permitted**
Event Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with HRSSC**
	become eligible for Medicare and want to change plans or options, see 1L) • TRICARE for Life, due to enrollment in Medicare • TRICARE due to change in employment status, including: (1) entry into active military service, (2) retirement from reserve military service under chapter 67, title 10 • Health insurance acquired due to change of worksite or residence that affects eligibility for coverage • Health insurance acquired due to spouse's or dependent's change in employment status (includes state, local or foreign government or private sector employment) [8]						

	Qualifying Life Events (QLEs) That May Permit Change in Enrollment or **Election of Pre-Tax vs. After-Tax Payment of Premiums**	**Permitted Enrollment Change**			**Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums**		**Time Limits in Which Change May Be Permitted**
Event Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with HRSSC**
1Q	Change in spouse's or dependent's coverage options under health plan other than the USPS Non-Career Employee Health Plan, for example: • Employer starts or stops offering a different type of coverage (If no other coverage is available, also see 1M) • Change in cost of coverage • HMO adds a geographic service area that now makes spouse eligible to enroll in that HMO • HMO removes a geographic area that makes spouse ineligible for coverage under that HMO, but other plans or options are available (If no other coverage is available, see 1M)	No	No	Yes	Yes	Yes	Within 60 days after QLE
1R	Employee or eligible family member becomes eligible for	Yes	Yes	Yes	Yes	Yes	Within 60 days after the date employee or family member becomes eligible for

	Qualifying Life Events (QLEs) That May Permit Change in Enrollment or **Election of Pre-Tax vs. After-Tax Payment of Premiums**	**Permitted Enrollment Change**			**Permitted Election of Pre-Tax vs. After-Tax Payment of Premiums**		**Time Limits in Which Change May Be Permitted**
Event Code	**Event**	**From Not Enrolled to Enrolled**	**From Self Only to Self and Family**	**Cancel or Change to Self Only[1]**	**Participate**	**Waive**	**When You Must File Health Benefits Election with HRSSC**
	assistance under Medicaid or a State Children's Health Insurance Program (CHIP).						assistance.

[1] Employees may change to Self Only outside of Open Season only if the QLE caused the enrollee to be the last eligible family member under the FEHB enrollment. Employees may cancel enrollment outside of Open Season only if the QLE caused the enrollee and all the eligible family members to acquire other health insurance coverage. Employees paying premiums post-tax may cancel enrollment or change from Self and Family to Self Only at any time.

[2] Employees who enter active military service are given the opportunity to terminate coverage. Additional information on the coverage of employees who return from active military service is available from the H.R. Shared Service Center, 1-877-477-3273, option 5; TTY 1-866-260-7507.

[3] Employees who begin nonpay status or insufficient pay must be given an opportunity to elect to continue or terminate coverage.

[4] This code reflects the FEHB regulation that gives employees enrolled in an FEHB HMO who change from Self Only to Self and Family or from one plan or option to another a different time frame than that allowed under 1M. For change to Self Only, cancellation, or change in premium conversion status see 1M.

[5] This code reflects the FEHB regulation that gives employees enrolled in FEHB a one-time opportunity to change plans or options under a different timeframe than that allowed by 1P. For change to Self Only, cancellation, or change in premium conversion status, see 1P.

[6] If employee's membership terminates, (e.g., for failure to pay membership dues), the employee organization will notify the agency to terminate the enrollment.

[7] Employee's failure to select another FEHB plan is deemed a cancellation.

[8] Under IRS rules, this includes start/stop of employment or nonpay status, strike or lockout, and change in worksite.

[9] Employees may change to Self Only outside of Open Season only if the QLE caused all eligible family members to acquire other health insurance coverage. Employees may cancel enrollment outside of Open Season only if the QLE caused the enrollee and all eligible family members to acquire other health insurance coverage.

SECTION 3 - PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Plan.

Prescription Drug Coverage Highlights

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

Note: The medical Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 3, *Prescription Drugs*.

The medical Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 3, *Prescription Drugs*.

Retail[1 2]	You Pay	The Plan Pays
Tier 1 drugs	$10.	The balance
Tier 2 and tier 3 drugs	Prior to satisfying the deductible: You pay the whole cost.	The plan pays nothing.
Tier 2 and tier 3 drugs	After satisfying the plan year deductible: You pay 30% of the cost of the prescription to a maximum of $250.	The plan pays the balance.
Tier 1, 2, or 3 drugs	After you have reached the annual OOP limit: You pay nothing.	The plan pays the full cost.

Mail Order[1 2]	You Pay	The Plan Pays
Tier 1 drugs	$25.	The balance
Tier 2 and tier 3 drugs	You pay 30% of the cost of the prescription to a maximum of $625	The plan pays the balance.
Tiers 1, 2, and 3 drugs	After you have reached the annual OOP limit	The plan pays the full cost.

[1]You must obtain prior authorization from UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

[2]You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications. This includes Tier 1 contraceptives and services. 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.

Note: The Coordination of Benefits provision described in Section 11, *Coordination of Benefits (COB)* applies to covered Prescription Drugs as described in this section. Benefits for Prescription Drugs will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

Identification Card (ID Card)

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

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

Benefit Levels

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

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, you can visit **www.myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay or Coinsurance, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay or Coinsurance will also depend on whether or not you visit the pharmacy or use the mail order service - see

the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Coinsurance option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Coinsurance option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

Coinsurance for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge

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

- the applicable Copay or Coinsurance;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Charge that UnitedHealthcare agreed to pay the Network Pharmacy.

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

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

Retail

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

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

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay or Coinsurance that applies will reflect the number of days dispensed; and

- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time.
- If you purchase a Prescription Drug from a non-Network Pharmacy, you will be required to pay full price and will not receive reimbursement under the Plan.

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

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail from a Network Pharmacy. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form, or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

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

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

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

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

Maintenance Medication Program

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

Benefits for Preventive Care Medications

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

Designated Pharmacy

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

Specialty Prescription Drugs

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

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

Want to lower your out-of-pocket Prescription Drug costs?
Consider Tier-1 Prescription Drugs, if you and your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

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

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

Economic factors may include:

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

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

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

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

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

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

Prior Authorization Requirements

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

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 15, *Glossary*.

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

Network Pharmacy Prior Authorization

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

If UnitedHealthcare has not provided prior authorization before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. If UnitedHealthcare has not provided prior authorization before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 10, *Claims Procedures*, for information on how to file a claim.

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

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

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

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

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 10, *Claims Procedures*.

Limitation on Selection of Pharmacies

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

Supply Limits

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

Note: Some products are subject to additional supply limits based on criteria that the USPS and UnitedHealthcare have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name Drug may change and an Ancillary Charge may apply. As a result, your Copay may change. You will pay the Copay or Coinsurance applicable for the tier to which the Prescription Drug is assigned.

Prescription Drugs that are Chemically Equivalent

If two drugs are chemically equivalent (they contain the same active ingredient) and you or your Physician choose not to substitute a lower tiered drug for the higher tiered drug, you will pay the difference between the higher tiered drug and the lower tiered drug, in addition to the higher tiered drug's Copayment or Coinsurance up to tier 3. This difference in cost is called an Ancillary Charge. An Ancillary Charge may apply when a covered Prescription Drug is dispensed at your or the provider's request and there is another drug that is

chemically the same available at a lower tier. An Ancillary Charge does not apply to the Annual Deductible or Out-of-Pocket Maximum.

Special Programs

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

Step Therapy

Certain Prescription Drugs for which Benefits are described in this section or Pharmaceutical Products for which Benefits are described under your medical Benefits are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drugs and/or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Products(s) first.

You may determine whether a particular Prescription Drug or Pharmaceutical Product is subject to step therapy requirements by visiting **www.myuhc.com** or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and the United States Postal Service may, at times, receive rebates for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you or does not apply them toward your Annual Deductible.

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

Coupons, Incentives and Other Communications

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

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

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 9, *Exclusions* apply also to this Section 3. In addition, the exclusions listed below apply.

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

The Plan excludes medications that are:

1. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;

2. any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;

3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 3, *Prescription Drugs*) portion of the Plan;

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

4. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Examples of these would include Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent and certain Prescription Drugs that the USPS has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the USPS may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;

5. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that contain a non-FDA approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug. Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3;

6. dispensed by a non-Network Pharmacy;

7. dispensed outside of the United States, except in an Emergency;

8. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);

9. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition);

10. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;

11. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;

12. certain Prescription Drugs that have not been prescribed by a specialist physician;

13. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;

14. prescribed, dispensed or intended for use during an Inpatient Stay;

15. prescribed for appetite suppression, and other weight loss products;

16. prescribed to treat infertility;

17. Prescription Drugs, including new Prescription Drugs or new dosage forms, that UnitedHealthcare and the United States Postal Service determines do not meet the definition of a Covered Health Service;

18. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;

19. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug;

20. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;

21. unit dose packaging of Prescription Drugs;

22. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and the United States Postal Service have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 15, *Glossary*;

23. used for cosmetic purposes;

24. vitamins, except for the following which require a prescription:

    - prenatal vitamins;
    - vitamins with fluoride; and
    - single entity vitamins.

Glossary - Prescription Drugs

Ancillary Charge – a charge, in addition to the Copayment, that you are required to pay when a covered Prescription Drug is dispensed at your or the provider's request, when a chemically equivalent Prescription Drug is available on a lower tier. For Prescription Drugs from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or MAC List price for Network Pharmacies for the Prescription Drug on the higher tier, and the Prescription Drug Charge or MAC List price of the chemically equivalent Prescription Drug available on the lower tier.

Brand-name - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Designated Pharmacy – a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

List of Preventive Medications – a list that identifies certain Prescription Drugs, which may include certain Specialty Prescription Drug Products, on the Prescription Drug List that are intended to reduce the likelihood of Sickness. You may obtain the List of Preventive Medications through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

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

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

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Claims Administrator as a Network Pharmacy.

PDL - see Prescription Drug List (PDL) below.

PDL Management Committee - see Prescription Drug List (PDL) Management Committee below.

Prescription Drug - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
  - insulin syringes with needles;
  - blood testing strips - glucose;
  - urine testing strips - glucose;
  - ketone testing strips and tablets;
  - lancets and lancet devices;
  - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
  - glucose monitors.

Prescription Drug Charge – the rate the Claims Administrator has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto **www.myuhc.com**.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy and that are payable at 100% of the Prescription Drug Charge (without application of any Copayment, Coinsurance, Annual Deductible, Annual Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

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

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

Specialty Prescription Drug - Prescription Drug that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. Specialty Prescription Drugs may include drugs on the List of Preventive Medications. For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutically Equivalent – when Prescription Drugs have essentially the same efficacy and adverse effect profile.

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

SECTION 4 - HOW THE PLAN WORKS

What this section includes:

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

Network Benefits

As a participant in this Plan, you have the freedom to choose the Network Physician or health care professional you prefer each time you need to receive Covered Health Services.

You are eligible for Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services. **Except as specifically described within the SPD, benefits are not available for services provided by a non-Network provider.**

Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Benefits for facility services apply when Covered Health Services are provided at a Network facility. Benefits include Physician services provided in a Network facility by a Network or a non-Network anesthesiologist, Emergency room Physician, consulting Physician, pathologist and radiologist. **Emergency Health Services and Covered Health Services received at an Urgent Care Center outside your geographic area are always paid as Network Benefits.**

Network Providers

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

Network providers are independent practitioners and are not employees of the United States Postal Service or UnitedHealthcare.

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

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

Possible Limitations on Provider Use

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

Health Services from Non-Network Providers Paid as Network Benefits

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

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

Eligible Expenses

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

Eligible Expenses are the amount the Claims Administrator determines that the Claims Administrator will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. Eligible Expenses are determined solely in accordance with the Claims Administrator's reimbursement policy guidelines, as described in the SPD.

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

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

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

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits. The amounts you pay toward your Annual Deductible accumulate over the course of the calendar year.

The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 3, *Prescription Drugs*.

Copayment

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

Coinsurance

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

Coinsurance – Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 70% after you meet the Annual Deductible, you are responsible for paying the other 30%. This 30% is your Coinsurance.

Out-of-Pocket Maximum

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

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 3, *Prescription Drugs*.

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

Plan Features	Applies to the Out-of-Pocket Maximum?
Copays, even those for Covered Health Services available in Section 3*, Prescription Drugs*.	Yes
Payments toward the Annual Deductible	Yes
Coinsurance Payments, even those for Covered Health Services available in Section 3, *Prescription Drugs*	Yes
Charges for non-Covered Health Services	No

SECTION 5 - PERSONAL HEALTH SUPPORT

What this section includes:

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

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

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

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

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

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

and share important health care information related to the participant's specific chronic or complex condition.

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

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a UnitedHealthcare Network are responsible for obtaining prior authorization. There are some Benefits, however, for which you are responsible for obtaining authorization before you receive the services. Services for which prior authorization is required are identified below and in Section 7, *Additional Coverage Details* within each Covered Health Service category.

It is recommended that you confirm with UnitedHealthcare that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact UnitedHealthcare to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

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

Covered Health Services which Require Prior Authorization

In most cases, Network providers are responsible for notifying Personal Health Support before they provide these services to you. However, you are responsible for notifying the Personal Health Support staff prior to receiving a service for:

- ambulance – non-emergent air;
- Clinical Trials;
- Congenital heart disease surgeries;
- Genetic Testing – BRCA (BReast CAncer);
- transplants.

Notification is required within 48 hours of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For notification timeframes see Section 7, *Additional Coverage Details*.

Please note that prior authorization is required for the above Covered Health Services even if you have a referral from your Primary Physician to seek care from another Network Physician.

Contacting Personal Health Support is easy.
Simply call the toll-free number on your ID card.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 11, *Coordination of Benefits (COB)*.

SECTION 6 - PLAN HIGHLIGHTS

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

Plan Features	Network
Copays[1,2]	
■ Emergency Health Services	$300
■ Hospital - Inpatient Stay	$500/day (Days 1 through 4)
■ Physician's Office Services - Primary Physician	$30
■ Physician's Office Services - Specialist	$60
■ Urgent Care Center Services	$75
Annual Deductible[2,3]	
■ Individual	$1,500
■ Family (not to exceed $1,500 per Covered Person)	$3,000
Annual Out-of-Pocket Maximum[2,4]	
■ Individual	$5,000
■ Family (not to exceed $5,000 per Covered Person)	$10,000
Lifetime Maximum Benefit[5]	
There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited

[1]In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart.

[2]Copays do not apply toward the Annual Deductible but do apply towards the Out-of-Pocket Maximum. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

[3]The Annual Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 3, *Prescription Drugs*.

[4]The Annual Out-of-Pocket applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 3, *Prescription Drugs*.

[5]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.

The following table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 7, *Additional Coverage Details*.

Covered Health Services[1]	**Percentage of Eligible Expenses Payable by the Plan:**
	Network
Acupuncture Services (Copay is per visit) Up to 24 treatments per calendar year	100% after you pay a $60 Copay
Ambulance Services ■ Emergency Ambulance ■ Non-Emergency Ambulance	 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.
Congenital Heart Disease (CHD) Surgeries ■ Hospital - Inpatient Stay (Copay is per day)	100% after you pay a $500 Copay per day for days 1 through 4 of a Hospital Inpatient Stay; starting on day 5 of a Hospital Inpatient Stay, Plan pays 70%
Dental Services - Accident Only	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.
■ Diabetes Self-Management Items	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under *Durable Medical Equipment* in this section and in Section 3, *Prescription Drugs*.
Durable Medical Equipment (DME)	70% after you meet the Annual Deductible
Emergency Health Services - Outpatient Emergency services received at a non-Network Hospital are covered at the Network level. If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay. The Benefits for an Inpatient Stay in a Hospital will apply instead.	100% after you pay a $300 Copay; OR 50% after you pay a $300 Copay for services that do not meet the definition of an Emergency.
Hearing Aids Up to one hearing aid per ear every 3 calendar years	100%
Home Health Care	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Hospice Care	70% after you meet the Annual Deductible
Hospital - Inpatient Stay (Copay is per day)	100% after you pay a $500 Copay per day for days 1 through 4 of a Hospital Inpatient Stay; starting on day 5 of a Hospital Inpatient Stay, Plan pays 70%
Lab, X-Ray and Diagnostics - Outpatient	70% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	70% after you meet the Annual Deductible
Mental Health Services	
■ Hospital - Inpatient Stay (Copay is per day)	100% after you pay a $500 Copay per day for days 1 through 4 of a Hospital Inpatient Stay; starting on day 5 of a Hospital Inpatient Stay, Plan pays 70%
■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay
Neurobiological Disorders - Autism Spectrum Disorders Services	
■ Hospital - Inpatient Stay (Copay is per day)	100% after you pay a $500 Copay per day for days 1 through 4 of a Hospital Inpatient Stay; starting on day 5 of a Hospital Inpatient Stay, Plan pays 70%
■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay
Nutritional Counseling	70% after you meet the Annual Deductible
Ostomy Supplies	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Pharmaceutical Products - Outpatient	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury (Copay is per visit)	
■ Primary Physician	100% after you pay a $30 Copay
■ Specialist Physician	100% after you pay a $60 Copay
■ Allergy care (injections, serum and antigens) or other covered injections	70% after you meet the Annual Deductible
■ 2nd and 3rd opinions	100% after you pay a $30 Copay if received in Physician's office setting, OR 70% after you meet the Annual Deductible
Pregnancy - Maternity Services	Benefits will be the same as those stated under each Covered Health Service category in this section.
Family Planning Services	
■ Sterilization	100% for females; OR 70% after you meet the Annual Deductible for males
■ IUDs and diaphragms (device, fitting and removal)	100%
A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	
Preventive Care Services	
■ Physician Office Services	100%
■ Lab, X-ray or Other Preventive Tests (one vision screening and one hearing screening per calendar year limited to Dependent Children).	100%
■ Breast Pumps	100%
Prosthetic Devices	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Reconstructive Procedures	
■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay/ $60 Copay for Specialist
■ Hospital - Inpatient Stay (Copay is per day)	100% after you pay a $500 Copay per day for days 1 through 4 of a Hospital Inpatient Stay; starting on day 5 of a Hospital Inpatient Stay, Plan pays 70%
■ Physician Fees for Surgical and Medical Services	70% after you meet the Annual Deductible
■ Prosthetic Devices	70% after you meet the Annual Deductible
■ Surgery - Outpatient	100% after you pay a $30 Copay/$60 Copay for Specialist for services received in a Physician's office; OR 70% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Copay is per visit) See Section 7, *Additional Coverage Details*, for visit limits	100% after you pay a $60 Copay
■ Manipulative Treatment	100% after you pay a $60 Copay
■ Post Cochlear implant aural therapy	70% after you meet the Annual Deductible for services received in an outpatient facility; OR 100% after you pay a $60 Copay
Scopic Procedures - Outpatient Diagnostic and Therapeutic	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services See Section 7, *Additional Coverage Details*, for visit limits	70% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of Eligible Expenses Payable by the Plan:
	Network
Substance Use Disorder Services	
■ Hospital - Inpatient Stay (Copay is per day)	100% after you pay a $500 Copay per day for days 1 through 4 of a Hospital Inpatient Stay; starting on day 5 of a Hospital Inpatient Stay, Plan pays 70%
■ Physician's Office Services (Copay is per visit)	100% after you pay a $30 Copay
Surgery - Outpatient	100% after you pay a $30 Copay/$60 Copay for Specialist for services received in a Physician's office; OR 70% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	70% after you meet the Annual Deductible
Transplantation Services (If services rendered by a Designated Facility)	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section.
Travel and Lodging (If services rendered by a Designated Facility)	For patient and companion(s) of patient undergoing Congenital Heart Disease treatment or transplant procedures
Urgent Care Center Services (Copay is per visit)	100% after you pay a $75 Copay
Wigs (for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury)	100%

[1]In general, your Network provider must obtain prior authorization from Personal Health Support, as described in Section 5, before you receive certain Covered Health Services. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization from Personal Health Support. See Section 7, *Additional Coverage Details* for further information.

SECTION 7 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization from Personal Health Support before you receive them.

This section supplements the second table in Section 6, *Plan Highlights*.

While the table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 9, *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

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

- chemotherapy;
- Pregnancy; and
- post-operative procedures.

Benefits are limited to 24 treatments per calendar year.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 15, *Glossary* for the definition of Emergency.

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

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

- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

Prior Authorization Requirement
In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must obtain prior authorization as soon as possible prior to transport.

Clinical Trials – - Routine Patient Care Costs

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

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

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

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

Routine patient care costs for qualifying Clinical Trials include:

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

Routine costs for Clinical Trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
  - certain *Category B* devices (as explained below);
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with UnitedHealthcare's medical and drug policies;
    Category B device; for the purposes of the FDA process, refers to an instrument, apparatus, implement, machine, contrivance, implant, in-vitro reagent, or other similar or related article, including any component or part. The *Category B* devices are Non-Experimental, but still Investigational;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying Clinical Trial is a Phase I, Phase II, or Phase III Clinical Trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
  - National Institutes of Health (NIH). (Includes National Cancer Institute (NCI));
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - a cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Veterans Administration (VA);
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
  - The Department of Veterans Affairs, the Department of Defense or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:

    - comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and

- ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the Clinical Trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization Requirement
You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises.

Congenital Heart Disease (CHD) Surgeries

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

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

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

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

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;

- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Please remember that you should obtain prior authorization from United Resource Networks or Personal Health Support as soon as CHD is suspected or diagnosed.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Dental Services - Accident Only

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

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

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

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

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;

- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

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

Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Insulin pumps and related pump supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under Durable Medical Equipment in this section.

Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 3, Prescription Drugs.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under Durable Medical Equipment in this section.

Durable Medical Equipment (DME)

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

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

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

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related pump necessary supplies as described under Diabetes Services in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy and Surgery - Outpatient in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage;
- cranial banding (helmets); and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

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

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

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

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

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

Emergency Health Services - Outpatient

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

If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, no Benefits will be paid.

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

> Please remember that you should notify Personal Health Support within 48 hours of the admission or on the same day of admission if reasonably possible if you are admitted to a non-Network Hospital as a result of an Emergency.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for the charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

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

Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three calendar years.

Home Health Care

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

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 15, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 15, *Glossary* for the definition of Skilled Care.

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

Hospice Care

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

Hospital - Inpatient Stay

Hospital Benefits are available for:

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

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

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-

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

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

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

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

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

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

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

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

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

Mental Health Services

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

Benefits include the following services:

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

The Mental Health/Substance Use Disorder Administrator determines coverage for 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.

Neurobiological Disorders - Autism Spectrum Disorders Services

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

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and

- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

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

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

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.

Nutritional Counseling

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- 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.

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;

- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

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

Ostomy Supplies

Benefits for ostomy supplies are limited to:

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

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Physician Fees for Surgical and Medical Services

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

Physician's Office Services - Sickness and Injury

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

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

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

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/x-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

Please remember that you should obtain prior authorization from Personal Health Support for Genetic Testing – BRCA (BReast CAncer)

Please Note
Your Physician does not have a copy of your Summary Plan Description, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

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

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

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

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

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

Healthy moms and babies
The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 8, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to

have a beneficial effect on health outcomes and include the following as required under applicable law:

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

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

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

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

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition;

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and
- tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis.

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

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

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

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

Benefits are provided for the replacement of a type of prosthetic device once every three calendar years.

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 three 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.

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

Reconstructive Procedures

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

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

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry.

Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 15, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- vision therapy (limited to the treatment of amblyopia (lazy eye) and strabismus (cross-eye) in dependent children up through age 18);
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

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

Benefits are limited to:

- 60 visits per calendar year for physical therapy;
- 60 visits per calendar year for occupational therapy;
- 60 visits per calendar year for speech therapy; and
- 20 visits per calendar year for Manipulative Treatment.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

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

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

Benefits under this section include:

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

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

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

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

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

- non-Physician services and supplies received during the Inpatient Stay;

- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

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

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

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

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

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

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

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in Section 15, *Glossary*.

Benefits are limited to 60 days per calendar year.

Substance Use Disorder Services

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

Benefits include the following services:

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

The Mental Health/Substance Use Disorder Administrator determines coverage for 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 Substance Use Disorder Programs and Services

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

Surgery - Outpatient

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

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under Physician Fees for Surgical and Medical Services.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Therapeutic Treatments - Outpatient

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

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

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

Benefits under this section include:

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

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a Network provider and received at a Designated Facility. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include, but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;

- pancreas;
- intestinal; and
- bone marrow (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.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from United Resource Networks or Personal Health Support for a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

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.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on the back of your ID card for information about these guidelines.

Prior Authorization Requirement
You must obtain prior authorization from the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Benefits will not be paid.

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD); and
- transplantation services.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to $50 per day for the patient or up to $100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to $100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility (for transplantation) or the CHD facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A maximum Benefit of $10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures and CHD treatments during the entire period that person is covered under this Plan.

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

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 15, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental Injury.

SECTION 8 - RESOURCES TO HELP YOU STAY HEALTHY

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

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

The United States Postal Service believes in giving you the tools you need to be an educated health care consumer. To that end, the USPS has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

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

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

Consumer Solutions and Self-Service Tools

Health Assessment

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

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way. To find the health assessment, log on to **www.myuhc.com**. Next, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

Health Improvement Plan

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

Online coaching is available for:

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

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

NurseLine℠

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

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

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

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

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

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

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

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

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:

- 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; and
- coronary disease.

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.

UnitedHealth Premium℠ Program

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

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

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

www.myuhc.com

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

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

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

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

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

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

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

Disease and Condition Management Services

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. Coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), diabetes and asthma programs are designed to support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
  - education about the specific disease and condition,
  - medication management and compliance,
  - reinforcement of on-line behavior modification program goals,
  - preparation and support for upcoming Physician visits,
  - review of psychosocial services and community resources,
  - caregiver status and in-home safety,
  - use of mail-order pharmacy and Network providers.

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

HealtheNotes℠

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

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified as those whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 15, *Glossary* under the definition of Covered Health Services.

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

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

Wellness Programs

Healthy Pregnancy Program

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

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

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

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

SECTION 9 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 7, *Additional Coverage Details*.

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

When Benefits are limited within any of the Covered Health Services categories described in Section 7, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 6, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 6, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

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

Alternative Treatments

1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 7, *Additional Coverage Details*.

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 7, *Additional Coverage Details*;

   Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment

of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

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

   - extractions (including wisdom teeth);
   - restoration and replacement of teeth;
   - medical or surgical treatments of dental conditions; and
   - services to improve dental clinical outcomes;

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 7, *Additional Coverage Details*.

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

   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in Section 7, *Additional Coverage Details*.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

   This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 7, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

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

2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 7, *Additional Coverage Details*:

   Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

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

   - blood pressure cuff/monitor;
   - enuresis alarm;

- non-wearable external defibrillator;
- trusses;
- ultrasonic nebulizers;

4. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;

5. the replacement of lost or stolen prosthetic devices;

6. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 7, *Additional Coverage Details*;

7. oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 3, *Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;

2. self-injectable medications. (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);

3. growth hormone therapy;

4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and

5. over-the-counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 15, *Glossary*.

   This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

   This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 7, *Additional Coverage Details*.

Foot Care

1. hygienic and preventive maintenance foot care. Examples include:

   - cleaning and soaking the feet;
   - applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

   This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes. This exclusion does not apply to cutting and removal of corns and calluses; nail trimming or cutting; and debriding (removal of dead skin or underlying tissue) for all Covered Employees regardless of diagnosis;

2. treatment of flat feet;

3. treatment of subluxation of the foot;

4. shoe inserts (unless prescribed by a Physician);

5. arch supports (unless prescribed by a Physician);

6. shoes (standard or custom), lifts and wedges (unless prescribed by a Physician); and

7. shoe orthotics (unless prescribed by a Physician).

Medical Supplies and Equipment

1. prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:

   - compression stockings, ace bandages, diabetic strips, and syringes; and
   - urinary catheters.

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 7, *Additional Coverage Details*.
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 7, *Additional Coverage Details*; or
   - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 7, *Additional Coverage Details*.
2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;

4. the replacement of lost or stolen Durable Medical Equipment; and

5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under Ostomy Supplies in Section 7, *Additional Coverage Details*.

Mental Health/Substance Use Disorder

In addition to all other exclusions listed in this Section 9, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders Autism Spectrum Disorder Services* and/or *Substance Use Disorder Services* in Section 7, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

2. health services or supplies that do not meet the definition of a Covered Health Service – see the definition in Section 15, *Glossary*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:

   - Medically Necessary;
   - described as a Covered Health Service in this Plan under Section 6, *Plan Highlights* and Section 7, *Additional Coverage Details*; and
   - Not otherwise excluded in this Plan under this Section 9, *Exclusions*;

3. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;

5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;

6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;

7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;

8. learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

9. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

11. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;

13. intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder; 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.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;

2. food of any kind. Foods that are not covered include:

   - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
   - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
   - oral vitamins and minerals;
   - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
   - other dietary and electrolyte supplements; and

3. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;

2. telephone;

3. beauty/barber service;

4. guest service;

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

- air conditioners;
- air purifiers and filters;
- batteries and battery chargers;
- dehumidifiers and humidifiers;
- ergonomically correct chairs;
- non-Hospital beds, comfort beds, motorized beds and mattresses;
- breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
- car seats;
- chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
- exercise equipment and treadmills;
- hot tubs, Jacuzzis, saunas and whirlpools;
- medical alert systems;
- music devices;
- personal computers;
- pillows;
- power-operated vehicles;
- radios;
- strollers;
- safety equipment;
- vehicle modifications such as van lifts;
- video players; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 15, *Glossary*, are excluded from coverage. Examples include:

   - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
   - pharmacological regimens;
   - nutritional procedures or treatments;
   - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
   - hair removal or replacement by any means;
   - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
   - treatment for spider veins;
   - skin abrasion procedures performed as a treatment for acne;
   - treatments for hair loss;
   - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
   - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;

3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity; and

4. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;

2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);

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

4. speech therapy to treat stuttering, stammering, or other articulation disorders;

5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 7, *Additional Coverage Details*;

6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;

7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);

8. psychosurgery (lobotomy);

9. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;

10. chelation therapy, except to treat heavy metal poisoning;

11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;

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

13. sex transformation operations and related services;

14. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity even if there is a diagnosis of morbid obesity;

15. medical and surgical treatment of hyperhidrosis (excessive sweating);

16. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature;

17. upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors or cancer or obstructive sleep apnea; and

18. breast reduction surgery that is determined to be a Cosmetic Procedure.

    This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 7, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;

2. a provider may perform on himself or herself;

3. performed by a provider with your same legal residence;

4. ordered or delivered by a Christian Science practitioner;

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

6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;

7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and

8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:

- prior to ordering the service; or
- after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment

   This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);
3. in vitro fertilization regardless of the reason for treatment;
4. surrogate parenting, donor eggs, donor sperm and host uterus;
5. the reversal of voluntary sterilization;
6. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
7. services provided by a doula (labor aide); and
8. parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 11, *Coordination of Benefits (COB)*;
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 7*, Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;

2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available);

3. transplants that are not performed at a Designated Facility (this exclusion does not apply to cornea transplants); and

4. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

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

2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 7, *Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 7, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 15, *Glossary* or maintenance care;

2. Domiciliary Care, as defined in Section 15, *Glossary;*

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

4. Private Duty Nursing;

5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 7, *Additional Coverage Details*;

6. rest cures;

7. services of personal care attendants;

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

Vision and Hearing

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

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

3. purchase cost and associated fitting charges for eyeglasses or contact lenses (except for (treatment of amblyopia (lazy eye) and strabismus (cross-eye) in dependent children up through age 18);

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

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

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

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

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms; or
   - record processing.

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

4. diagnostic tests that are:

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

5. expenses for health services and supplies:

   - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;

- that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
- for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
- that exceed Eligible Expenses or any specified limitation in this SPD;

6. foreign language and sign language services;

7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;

8. health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 15, Glossary. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following:

   - Medically Necessary;
   - described as a Covered Health Service in this Summary Plan Description; and
   - not otherwise excluded in this Summary Plan Description under this Section 9, *Exclusions*.

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

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

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

    - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
    - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 7, *Additional Coverage Details*;
    - related to judicial or administrative proceedings or orders; or
    - required to obtain or maintain a license of any type.

SECTION 10 - CLAIMS PROCEDURES

What this section includes:

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

Network Benefits

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

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

Non-Network Benefits

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

Prescription Drug Benefit Claims

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

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

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

If Your Provider Does Not File Your Claim

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

- your name and address;
- the patient's name, age and relationship to the Employee;

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

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

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

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

When UnitedHealthcare has not consented to an assignment, UnitedHealthcare will send the reimbursement directly to you (the Employee) for you to reimburse the provider upon receipt of their bill. However, UnitedHealthcare reserves the right, in its discretion, to pay the provider directly for services rendered to you. When exercising its discretion with respect to payment, UnitedHealthcare may consider whether you have requested that payment of your Benefits be made directly to the provider. Under no circumstances will UnitedHealthcare pay Benefits to anyone other than you or, in its discretion, your provider. Direct payment to a provider shall not be deemed to constitute consent by UnitedHealthcare to an assignment or to waive the consent requirement. When UnitedHealthcare in its discretion directs payment to a provider, you remain the sole beneficiary of the payment, and the provider does not thereby become a beneficiary. Accordingly, legally required notices concerning your Benefits will be directed to you, although UnitedHealthcare may in its discretion send information concerning the Benefits to the provider as well. If payment to a provider is made, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan, pursuant to *Refund of Overpayments* in Section 11, *Coordination of Benefits*.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy

for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

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

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at **www.myuhc.com**. See Section 15, Glossary for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims
All claim forms for non-Network services must be submitted up to December 31st of the year following the year after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

NOTE: Except as specifically described within the SPD, benefits are not available for services provided by a Non-Network Provider.

Claim Denials and Appeals

If Your Claim is Denied

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

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. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

How to Appeal a Denied Claim

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

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

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

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

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

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

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

Review of an Appeal

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

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

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

Filing a Second Appeal

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

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 noted in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address noted 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.

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 an 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
- 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.

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

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

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

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

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

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by 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.

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 15, Glossary;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must obtain prior authorization from UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

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

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

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

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

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

The Determination of the IRO is final and binding on you, UHC, and the United States Postal Service.

Exhaustion of Administrative Remedies and Limitation of Action

If you attempt to bring a legal action against the United States Postal Service or the Claims Administrator for any reason, you must first complete all available steps of the appeal process described in this section to the extent the appeal process is applicable to your claim.

If you attempt to bring a legal action against the United States Postal Service or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your claim or you lose any rights to bring such an action against the United States Postal Service or the Claims Administrator.

Nothing in this section shall constitute a waiver by the United States Postal Service or the Claims Administrator of the right to assert any defenses that the United States Postal Service or the Claims Administrator may have to the legal action, including without limitation the final and binding nature of a determination by an IRO.

SECTION 11 - COORDINATION OF BENEFITS (COB)

What this section includes:

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

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

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

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

Don't forget to update your Dependents' Medical Coverage Information
Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to **www.myuhc.com** or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

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

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

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

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

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

When This Plan is Secondary

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

- the Plan determines the amount it would have paid based on the allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

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

Determining the Allowable Expense If This Plan is Secondary

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

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

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

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

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

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

Determining the Allowable Expense When This Plan is Secondary to Medicare

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

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

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

Overpayment and Underpayment of Benefits

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

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

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

Refund of Overpayments

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

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

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons

under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the Claims Administrator makes payments, with the understanding that the Claims Administrator will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 12 - SUBROGATION AND REIMBURSEMENT

What this section includes:

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement.

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

Subrogation – Example

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

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

Reimbursement – Example

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

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- 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), other insurance carriers or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

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

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

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal

representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights

and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

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

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

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

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

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

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

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

SECTION 13 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends.

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

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

When Will My Coverage End?

If you cancel your coverage as an Open Season transaction, the cancellation is effective at midnight of the day before the first day of the first pay period that begins in the next year. Since this is the first year the USPS Non-Career Employee Health Benefits Plan is being offered, it is impossible for you to be covered under this plan during the November 2013 Open Season and therefore you would not have any coverage to cancel this year. What you can do during the November-December 2013 Open Season is to delete a pending transaction to enroll.

For example, if on November 11, 2013, you enter an election in PostalEASE to enroll in the USPS Non-Career Employee Health Benefits Plan for 2014, you may go back into PostalEASE and delete your pending enrollment transaction, as long as you do this before the end of Open Season (5:00 PM Central Time December 10, 2013) and then you will not be enrolled for 2014.

Cancellations will be available for next year's Open Season. If you enroll in the USPS Non-Career Employee Health Benefits Plan for 2014, you will be able to cancel coverage as a November-December 2014 Open Season transaction, and in that case, your coverage would end at midnight on January 9, 2015. If you enroll in the USPS Non-Career Employee Health Benefits Plan for 2014, and you are paying your premiums with after-tax money and cancel your coverage as a Current Year transaction, the cancellation will be effective on the last day of the pay period in which your transaction is processed—you will not wait until January 9, 2015 for your coverage to end.

If you cancel your coverage outside of Open Season, your cancellation is effective on the last day of the pay period in which the HRSSC receives your PS 3117 PostalEASE USPS Non-Career Employee Health Benefits Plan Worksheet.

If you have Self and Family coverage, and you cancel your enrollment, either during Open Season or outside of Open Season, your family members' coverage terminates at midnight of the day that your cancellation is effective, with no 31-day extension of coverage.

Be sure to read the section below about "Loss of Coverage and the Opportunity to Elect Temporary Continuation of Coverage (TCC)".

Possible Loss of Coverage because of Insufficient Pay and Failure to Pay Premiums

Once you have enrolled in the USPS Non-Career Employee Health Benefits Plan, if you fail to earn sufficient pay to allow for withholding of your health benefits premium in one pay period, the Eagan Accounting Service Center (ASC) will withhold the unpaid premium in the following pay period, provided you have sufficient earnings to cover the unpaid premium.

When two adjustments for insufficient earnings for USPS Non-Career Employee Health Benefits Plan purposes have occurred because you did not have sufficient pay available, the Eagan ASC will send you an invoice for the total amount due. You must pay the total amount billed within 30 days of the date of the invoice.

If the Eagan ASC does not receive payment within 30 days, your health benefits enrollment will be cancelled, retroactive to the date the initial unpaid premium was due. You may be required to reimburse the health plan and/or the provider for any benefits that were provided, but are no longer available to you and/or your dependents because your family coverage was terminated retroactively.

NOTE: This debt cannot be paid on installments via a voluntary PS 3239.

If you lose USPS Non-Career Employee Health Benefits Plan coverage because of insufficient earnings, you will not be eligible to renew your enrollment until:

- The next health benefits Open Season; or
- You experience a qualifying life event that gives you an opportunity to enroll in USPS Non-Career Employee Health Benefits Plan Coverage.

Certificate of Group Health Plan Coverage

If you lose coverage under the USPS Non-Career Employee Health Benefits, you should automatically receive a Certificate of Group Health Plan Coverage from UnitedHealthcare. If not, they must give you one on request. This certificate may be important to qualify for benefits if you join another insurance plan.

Other Events Ending Your Coverage

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

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

Note: The United States Postal Service has the right to demand that you pay back Benefits the USPS paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Extended Coverage for Total Disability

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

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

Loss Of Coverage And The Opportunity To Elect Temporary Continuation Of Coverage (TCC)

When an event occurs that causes you or your family member to lose coverage, the USPS Non-Career Employee Health Benefits Plan offers a Temporary Continuation of Coverage (TCC) feature, as defined in Section 15, Glossary. TCC is administered by UnitedHealthcare. If you or a dependent lose coverage, for information about TCC you must promptly contact UnitedHealthcare for assistance at 1-888-496-6959. Employees who are deaf or hard of hearing may call this number via 711, the Telecommunications Relay Service (TRS). Events where you or a family member loses coverage include but are not limited to:

- Separation from employment
- Child reaching age 26
- Divorce
- Death
- Insufficient Pay

Temporary Continuation of Coverage under Federal Law (TCC)

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

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

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

Qualifying Events for Temporary Continuation of Coverage

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

If Coverage Ends Because of the Following Qualifying Events:	You May Elect TCC:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage[1]	29 months	29 months	29 months
You die[2]	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below

[1]Subject to the following conditions: (i) notice of the disability must be provided within the latest

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

[2]From the date of the Employee's death if the Employee dies during the continuation of coverage.

How Your Medicare Eligibility Affects Dependent TCC Coverage

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

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

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

Getting Started

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

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

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

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

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

Notification Requirements

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

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

You or your Dependents must also notify UnitedHealthcare when a qualifying event occurs that will extend continuation of coverage.

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

Once you have notified UnitedHealthcare, you will then be notified by mail of your election rights under TCC.

Notification Requirements for Disability Determination

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

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

When Temporary Continuation of Coverage (TCC) Ends

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

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

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

Uniformed Services Employment and Reemployment Rights Act

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

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

If qualified to continue coverage pursuant to the USERRA, Employees should notify the HRSSC in advance. Invoices for premium payment will be deferred while the Employee is out on military service. The premium payment may include the amount the USPS normally pays on an Employee's behalf. If an Employee's Military Service is for a period of time less than 31 days, the Employee may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

An Employee may continue Plan coverage under USERRA for up to the lesser of:

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

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

You should contact the HRSSC if you have questions about your rights to continue health coverage under USERRA.

SECTION 14 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and the United States Postal Service;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

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

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

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

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

Your Relationship with UnitedHealthcare and the United States Postal Service

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

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

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

Relationship with Providers

The relationships between the United States Postal Service, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not the United States Postal Service's agents or employees, nor are they agents or employees of UnitedHealthcare. The United States Postal Service and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

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

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

The United States Postal Service is solely responsible for:

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

Your Relationship with Providers

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

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;

- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

The United States Postal Service and UnitedHealthcare have the sole and exclusive discretion to:

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

The United States Postal Service and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

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

Information and Records

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

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

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

For complete listings of your medical records or billing statements the United States Postal Service recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

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

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

Incentives to Providers

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

Examples of financial incentives for Network providers are:

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

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

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but the United States Postal Service recommends that you discuss participating in such programs with your Physician. These incentives are not

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

Rebates and Other Payments

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

Workers' Compensation Not Affected

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

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to terminate or amend the Plan at any time consistent with its responsibilities under the law.

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

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

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

Plan Document

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

There is also a legal plan document containing the full legal plan provisions regarding the pre-tax payment of health insurance premium contributions, which you may arrange to view by writing to:

U.S.P.S. Non-Career Employee Health Benefits Plan
Plan Administrator
475 L'Enfant Plaza SW Room 9670
Washington, D.C. 20260-4101

SECTION 15 - GLOSSARY

What this section includes:
- Definitions of terms used throughout this SPD.

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

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

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

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

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

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

Annual Deductible (or Deductible) – the amount of Eligible Expenses you must pay for Covered Health Services in a calendar year before you are eligible to begin receiving Benefits in that calendar year. The Deductible is shown in the first table in Section 6, *Plan Highlights*. The Deductible applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 3, *Prescription Drugs*.

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

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

CHD – see Congenital Heart Disease (CHD).

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

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

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 4, *How the Plan Works*.

Company – the United States Postal Service.

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

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in Section 4, *How the Plan Works*.

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

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

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

- Medically Necessary;
- included in Sections 6 and 7, Plan Highlights and Additional Coverage Details described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under Eligibility in Section 2, Introduction; and
- not identified in Section 9, Exclusions.

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

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

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

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as an Employee. No one can be a Dependent of more than one Employee. A Dependent includes a spouse from a common law marriage and children from a common law marriage.

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

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

DME – see Durable Medical Equipment (DME).

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

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

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by the Claims Administrator as stated below and as detailed in Section 4, *How the Plan Works*.

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

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

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

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

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

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

Employer – the United States Postal Service.

EOB – see Explanation of Benefits (EOB).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the UHC 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:

- Clinical trials for which Benefits are available as described under Clinical Trials in Section 7, Additional Coverage Details.
- If you are not a participant in a qualifying Clinical Trial as described under Section 7, Additional Coverage Details, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, UHC 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, UHC must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

Genetic Testing – examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Human Resources Shared Service Center (HRSSC) – the Human Resources Shared Service Center.

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

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

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

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

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

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

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

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

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

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

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

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

Manipulative Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

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

Medically Necessary – healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders , condition, disease or its symptoms, that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and

- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

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

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

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

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

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 9, *Exclusions*.

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

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

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

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 6, *Plan Highlights* for details about how Network Benefits apply.

Open Season – the period of time, determined by the United States Postal Service, during which eligible Employees may enroll themselves and their Dependents under the Plan. The United States Postal Service determines the period of time that is the Open Season period.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to Section 6, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 4, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

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

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Products – U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

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

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

Plan – The United States Postal Service Non-Career Employee Health Benefits Plan.

Plan Administrator – The United States Postal Service or its designee.

Plan Sponsor – The United States Postal Service.

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

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

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

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

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

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

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Claims 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.

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.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance-related and addictive disorders , regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

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

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

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

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

Spouse – an individual to whom you are legally married. This includes a common-law spouse.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded.

TCC – see Temporary Continuation of Coverage (TCC).

Temporary Continuation of Coverage (TCC) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

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

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

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

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

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

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

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

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

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion,

consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

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

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

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

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

SECTION 16 - IMPORTANT ADMINISTRATIVE INFORMATION:

What this section includes:
- Plan administrative information.

This section includes information on the administration of the medical Plan. While you may not need this information for your day-to-day participation, it is information you may find important.

Additional Plan Description

Plan Sponsor and Administrator

U.S.P.S. Non-Career Employee Health Benefits Plan
Plan Administrator
475 L'Enfant Plaza SW Room 9670
Washington, D.C. 20260-4101

Claims Administrator: The Company which provides certain administrative services for the Plan Benefits described in this Summary Plan Description.

UnitedHealthcare 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.

TCC Administrator: The company which provides certain TCC administrative services for the Plan Benefits described in this Summary Plan Description.

UHC Benefit Services, UnitedHealth Group
9100 Shelbyville Road
Suite 300
Louisville, KY 40222
1-888-496-6959

The TCC 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 TCC Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

Type of Administration of the Plan: The Plan Sponsor provides certain administrative services in connection with its Plan. The Plan Sponsor may, from time to time in its sole discretion, contract with outside parties to arrange for the provision of other administrative services including arrangement of access to a Network Provider; claims processing services,

including coordination of benefits and subrogation; utilization management and complaint resolution assistance. This external administrator is referred to as the Claims Administrator. For Benefits as described in this Summary Plan Description, the Plan Sponsor also has selected a provider network established by United HealthCare Insurance Company. The named fiduciary of Plan is the United States Postal Service, the Plan Sponsor.

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

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

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

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

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

ATTACHMENT II - LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

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

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

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

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

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

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

ATTACHMENT III – EMPLOYEE ASSISTANCE PROGRAM (EAP)

The EAP Program described below is NOT administered by UnitedHealthcare. The administrator for the EAP Program is Magellan Health Services.

The Postal Service™ EAP is a free, voluntary, and confidential program that offers assessment, referral, short-term counseling, and life coaching to postal employees and their families. Among the things EAP can help with include: work stress, coping with change, family issues, relationship problems, anxiety, depression, grief/loss, anger management, elder care, financial concerns, parenting issues, substance abuse, and addiction issues.

The EAP also provides consultation services that focus on solving present-day issues and is usually situation-specific. The EAP also provides crisis response when requested and needed.

For information and assistance 24 hours a day, 7 days a week, call:

1-800-EAP-4-YOU (1-800-327-4968);

TTY: 1-877-492-7341;

or log on to: www.EAP4YOU.com.