

PRIESTS OF THE ARCHDIOCESE OF DUBUQUE DUBUQUE IA

Health Booklet

Revised 01-01-2022

BENEFITS ADMINISTERED BY



A UnitedHealthcare Company

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PRIESTS OF THE ARCHDIOCESE OF DUBUQUE

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You, if any, with summary information in English on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the PRIESTS OF THE ARCHDIOCESE OF DUBUQUE Health Benefit Plan (the "Plan"). You are a valued Ordained Priest of PRIESTS OF THE ARCHDIOCESE OF DUBUQUE, and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your health care needs. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions or if You have difficulty translating this document.

PRIESTS OF THE ARCHDIOCESE OF DUBUQUE is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and MedOne for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Ordained Priests help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Ordained Priest Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letter, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document. Therefore it will be referred to as both the SPD and the Plan document. It is being furnished to You in accordance with ERISA.

This document becomes effective on January 1, 2014.

PLAN INFORMATION

Plan Name	PRIESTS OF THE ARCHDIOCESE OF DUBUQUE GROUP BENEFIT PLAN
Name And Address Of Employer	PRIESTS OF THE ARCHDIOCESE OF DUBUQUE 1229 MOUNT LORETTA AVE DUBUQUE IA 52003
Name, Address And Phone Number Of Plan Administrator	PRIESTS OF THE ARCHDIOCESE OF DUBUQUE 1229 MOUNT LORETTA AVE DUBUQUE IA 52003 563-556-2580
Named Fiduciary	PRIESTS OF THE ARCHDIOCESE OF DUBUQUE
Employer Identification Number Assigned By The IRS	42-1096954
Type Of Benefit Plan Provided	Self-funded Health & Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	ARCHDIOCESE OF DUBUQUE 1229 MOUNT LORETTA AVE DUBUQUE IA 52003 Services of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	Ordained Priest Contributions Benefits are provided by a benefit Plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Ordained Priests, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
ERISA Plan Year	January 1 through December 31
ERISA And Other Federal Compliance	It is intended that this Plan comply with all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

BENEFIT CLASS DESCRIPTION

The Covered Person's benefit class is determined by the designations shown below:

Class	Class Description	Benefit Plan	Network**
A01	ALL ACTIVE ORDAINED PRIESTS PLAN 1	001	0L / SAG2

**Note: See the Provider Network section of this SPD for network description.

LOCATION DESCRIPTION

Location	Description	Billing Division	Reporting Sub
001	PRIESTS OF THE ARCHDIOCESE OF DUBUQUE 1229 MOUNT LORETTA AVE DUBUQUE IA 52003	001	0001

MEDICAL SCHEDULE OF BENEFITS

\$200 Deductible Plan

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the In-Network or Out-of-Network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that the Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per Calendar Year: • Per Person	\$200	\$450
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	90%	70%
Annual Out-Of-Pocket Maximum: • Per Person	\$750	\$1,250
Ambulance Transportation: • Paid By Plan After In-Network Deductible	90%	90%
Durable Medical Equipment: • Paid By Plan After Deductible	90%	70%
Emergency Services / Treatment: Urgent Care: • Paid By Plan After Deductible Emergency Room / Emergency Physicians: • Paid By Plan After In-Network Deductible	90% (Deductible Waived) 90%	70% 90%
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility: • Paid By Plan After Deductible	90%	70%
Hearing Services: • Paid By Plan After Deductible	90%	70%
Home Health Care Benefits: • Paid By Plan After Deductible <i>Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.</i>	90%	70%

	IN-NETWORK	OUT-OF-NETWORK
Outpatient Or Partial Hospitalization Services And Physician Charges: <ul style="list-style-type: none"> Paid By Plan After Deductible 	90%	70%
Office Visit: <ul style="list-style-type: none"> Paid By Plan After Deductible 	90% (Deductible Waived)	70%
Physician Office Visit: <ul style="list-style-type: none"> Paid By Plan After Deductible 	90% (Deductible Waived)	70%
Physician Office Services: <ul style="list-style-type: none"> Paid By Plan After Deductible 	90% (Deductible Waived)	70%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: Preventive / Routine Physical Exams At Appropriate Ages: <ul style="list-style-type: none"> Paid By Plan Immunizations: <ul style="list-style-type: none"> Paid By Plan Preventive / Routine Diagnostic Tests, Lab, And X-rays At Appropriate Ages: <ul style="list-style-type: none"> Paid By Plan Preventive / Routine PSA Test And Prostate Exams: <ul style="list-style-type: none"> Maximum Exams Per Calendar Year Paid By Plan Preventive / Routine Screenings / Services At Appropriate Ages And Gender: <ul style="list-style-type: none"> Paid By Plan Preventive / Routine Autism Screening: From Age 0 To 21 <ul style="list-style-type: none"> Paid By Plan Preventive / Routine / Medical Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons: <ul style="list-style-type: none"> Paid By Plan Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco Use, Obesity, Diet, And Nutrition: <ul style="list-style-type: none"> Paid By Plan 	100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 1 Exam 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived)	100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived) 100% (Deductible Waived)

	IN-NETWORK	OUT-OF-NETWORK
Prosthetics: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	90% (Deductible Waived)	70%
Temporomandibular Joint Disorder Benefits: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	90%	70%
Therapy Services: Occupational / Physical / Speech Outpatient Hospital Therapy: <ul style="list-style-type: none"> • Paid By Plan After Deductible Occupational / Physical / Speech Office Therapy: <ul style="list-style-type: none"> • Paid By Plan After Deductible <i>Note: Medical Necessity Will Be Reviewed After 25 Visits.</i>	90% 90% (Deductible Waived)	70% 70%
All Other Covered Expenses: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	90%	70%

TRANSPLANT SCHEDULE OF BENEFITS

\$200 Deductible Plan

Transplant Services At A Designated Transplant Facility:**Transplant Services:**

- Paid By Plan After Deductible

90%

Travel And Housing:

- Maximum Benefit Per Transplant
- Paid By Plan

\$10,000

100% (Deductible Waived)

Travel And Housing At Designated Transplant Facility
At Contract Effective Date/Pre-Transplant Evaluation
And Up To One Year From Date Of Transplant.

ARCHDIOCESE OF DUBUQUE PRIEST PRESCRIPTION DRUG BENEFIT

NOTE: UMR (the claims administrator) does not administer the benefits within this provision. Please contact the Benefit Manager or Your employer with any questions related to this coverage.

Effective Date: January 1, 2022

Rx Out-of-Pocket Maximums:

Individual \$6,150

Payment Structure - 30-Day Retail

Up to a 30-day supply of acute or maintenance medication is available at any retail network pharmacy (excluding all Sam's Club, Walgreens and Walmart locations).

Generic	\$5
Preferred Brand	\$10
Non-Preferred Brand	\$20

Payment Structure - 90-Day Mail-Order/Retail

Up to a 90-day supply of maintenance medication may be filled at any retail network pharmacy (excluding all Sam's Club, Walgreens and Walmart locations) and by mail-order with MedOne Pharmacy Services.

Mail-Order Pharmacy

Generic	\$10
Preferred Brand	\$20
Non-Preferred Brand	\$40

Network Pharmacy

Generic	\$15
Preferred Brand	\$30
Non-Preferred Brand	\$60

Specialty drugs: 20% drug cost up to \$400 maximum. Limited to a 30-day supply or less per fill. Special distribution applies. Please see current specialty drug list.

Specialty Drug included in the MedOne Copay Assist Program (Effective 1/1/2020):

30% coinsurance per drug per 30-day fill. Manufacturer assistance program covers most if not all of the coinsurance amount. Your out-of-pocket cost per 30-day supply will not exceed 20% up to a \$400 maximum. Claim cost incurred by drugs included in the MedOne Copay Assist Program will NOT apply toward the annual deductible and out-of-pocket maximum, as most or all of the payment will be paid by the manufacturer copay assistance program. If you have actual out-of-

pocket costs after the manufacturer copay assistance program has paid, you will pay \$0.

Site of care services: Nursing and supply fees included at a \$0 copay.

Bowel preparation medications: \$0 Co-pay. Limited to 1 per year.

Smoking cessation: Prescription and over-the-counter smoking cessation products (with an Rx) are available at a \$0 Co-pay.

Statins for primary prevention of CVD: Select low to moderate doses statins are free for members when used for primary prevention of CVD in high risk patients between ages 40-75. Prior authorization required.

Vaccinations

The following vaccinations are available at a \$0 Co-pay:

- COVID-19
- Flu
- Pneumonia
- Shingles (Zostavax-Age 60+ or Shingrix – Age 50+)
- Whooping cough

Check with retail network pharmacies for availability.

Excluded Drugs/Categories

- Anti-obesity drugs
- Contraceptives
- Diabetic glucose meters
- Fertility drugs
- Hair growth stimulants
- Hepatitis C medications
- Non-prescription/non-prenatal vitamins and supplements
- Nutritional diet supplements
- Ostomy supplies
- Over-the-counter (OTC) products except those listed as covered*
- Products for cosmetic indications

- Sexual dysfunction drugs
- Specialty medications for treatment of plaque psoriasis

***Over-the-Counter (OTC) drugs:** OTC smoking cessation treatments are covered by the plan. The physician must write a prescription specifically for an OTC item.

Drugs Requiring Prior Authorization

- Compounded drugs more than \$100
- Standard drug more than \$1,000
- Specialty medications
- ADHD/narcolepsy medications
- Androgens
- Growth hormones
- Inhalation/nasal smoking cessation products
- Isotretinoin
- Smoking cessation medications (for treatment more than 6 months)

This list is subject to change. Your Physician's office may obtain a prior authorization form by calling MedOne at 1-888-884-6331.

Drug Limitations

- Brand proton pump inhibitors for ulcers/GERD limited to 1 capsule or tablet per day
- Cholesterol medications limited to 1 dose per day
- Migraine medications limited to 6 injections, 8-12 nasal spray doses, or 6-12 tablets (depending on package size) per 30 days
- Sleep agents limited to 1 dose per day

Dispense As Written Penalty

If a Covered Person requests a brand drug when a generic drug is available, the Covered Person is responsible for the applicable Co-pay plus the difference in cost between the generic and brand drug.

Refill Too Soon Limitation

A prescription may not be refilled until at least 75% of the supply has been utilized. For example, if the Covered Person has a 30-day supply, 23 days must be utilized before the prescription could be refilled.

Benefit Plan Network

Your Plan includes a network of pharmacies locally and nationwide, excluding all Sam's Club, Walgreens and Walmart locations. Please refer to the listing of network pharmacies in this brochure. You may also call MedOne at 1-888-

884- 6331 for assistance in locating a network pharmacy.

Mail-Order

For assistance in setting up a mail-order account, see the mail-order section in this brochure or contact MedOne at 1-888-884-6331.

To download a mail-order form, go to www.MedOne-rx.com. Upon request, a copy of the mail-order brochure and order form can be sent by email, fax, or mail. Allow 10-14 days from the time the mail-order request is submitted until the prescription is delivered.

Important Information

Call 1-888-884-6331 for the following:

- Questions regarding the prescription drug benefits
- Locate a network pharmacy
- Set up a mail-order account
- Check the status of a mail-order delivery
- Order refills of a mail-order prescription

MedOne + Kannact Diabetic Program

Receive a dedicated health coach, free testing supplies, and real-time alert monitoring. For any questions, please contact Kannact at 855-722-5513

OUT-OF-POCKET EXPENSES AND MAXIMUMS

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits.

Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the applicable benefit level's total individual Deductible.

All Covered Expenses which are Incurred during the last three months of a Plan Year and applied toward satisfaction of the individual Deductible for that year, will also be applied toward the individual Deductible requirement for the next Plan Year.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses until the Covered Person's annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as the Deductible, Co-pays if applicable, and any Plan Participation expense, will be used to satisfy the Covered Person's annual in-network and out-of-network out-of-pocket maximum(s). Pharmacy expenses that the Covered Person incurs do not apply toward the out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Ordained Priests.

ELIGIBILITY REQUIREMENTS

An **eligible Ordained Priest** is a person who is classified by the employer on both payroll and personnel records as an Ordained Priest who regularly works full-time, but for purposes of this Plan, it does not include the following classifications of workers as determined by the employer in its sole discretion:

- Leased Ordained Priests.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Ordained Priest may retain eligibility for coverage under this Plan if the Ordained Priest is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. If an Ordained Priest loses full time employment due to the COVID-19 disaster declaration, their eligibility requirements will continue to be considered as met from March 13, 2020 through December 31, 2020. Ordained Priests who meet eligibility requirements during a measurement period as required by the ACA regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

Your group's stability period:

Ongoing Ordained Priests:

Stability period: 12 months
Measurement period: 12 months
Administration period timeframe: 31 days

New variable Ordained Priests:

Stability period: 12 months
Measurement period: 12 months
Start date of measurement period: First day of the month following the date of hire
Administration period timeframe: 1 + partial months

Note: Eligible Ordained Priests who decline to enroll in this Plan must state so in writing.

EFFECTIVE DATE OF ORDAINED PRIEST'S COVERAGE

Your coverage will begin on the later of the following dates:

- If You apply within 30 days of hire, Your coverage will become effective the first day of the month the Ordained Priest becomes an Ordained Priest; or
- If You apply after 30 days of hire, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective the date You apply for coverage.

TERMINATION

ORDAINED PRIEST'S COVERAGE

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

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except if You are temporarily absent from work due to active military duty. Refer to USERRA under the USERRA section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- It has only a prospective effect; or
- It is attributable to non-payment of premiums or contributions; or
- It is initiated by You or Your personal representative.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Ordained Priest.

Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact Your Human Resources or Personnel office.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Ordained Priests on leave for military service must be treated as if they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Ordained Priests on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Ordained Priests on military leave. Reinstatement following a military leave of absence cannot be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the Ordained Priest fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Ordained Priest or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Ordained Priest intends to leave the employment position to perform service in the uniformed services. An Ordained Priest should provide notice as far in advance as is reasonable under the circumstances. The Ordained Priest is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed services, Ordained Priests will be given the opportunity to elect USERRA continuation.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Ordained Priest is not required to pay more than the amount he or she would have paid as an active Ordained Priest. For periods of 31 days or longer, if an Ordained Priest elects to continue health coverage pursuant to USERRA, such Ordained Priest will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Election of USERRA extension by an Ordained Priest on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Ordained Priest will generally be extended. Coverage under both laws will run concurrently.

PROVIDER NETWORK

The word "**Network**" means an outside organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

UnitedHealthcare Choice Plus

Reimbursement for Covered Expenses received from Non-Network Physicians or health care facilities are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility;
- If fees have not been negotiated:
 - 110 percent of the published rates allowed by Centers for Medicare and Medicaid Services (CMS) for the same or similar service within the geographic market; or
 - A gap methodology may be utilized when CMS does not have rates published for certain procedural codes. In such instances, a rate methodology derived by OptumInsight will be utilized.
 - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by CMS and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealth Care* based on an internally developed pharmaceutical pricing resource; or
 - 50 percent of the provider's billed charges when unable to obtain a rate published by CMS and/or gap methodology does not apply.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

The program for Transplant Services at Designated Transplant Facilities is:

SunExcel

EXCEPTIONS TO THE PROVIDER NETWORK RATES

Some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with Network benefits, the charges may be subject to the Usual and Customary charge limitations. The following exceptions may apply:

- Ambulance transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered Services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist when services are provided at a Network facility or referred by an In-Network Physician, even if the provider is an Out-of-Network Provider.
- Covered Services provided by a Physician during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital.
- If there is not an In-Network provider, or no In-Network provider is willing or able to provide the necessary service(s) to the Covered Person within a 50 mile radius of the Covered Person's residence, then the Out-of-Network charges will be processed as In-Network charges so long as the Covered Person provides appropriate documentation.

Provider Directory Information

Each covered Ordained Priest, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Ordained Priest should share this document with other covered individuals in Your household.

TRANSITIONAL CARE

Certain eligible expenses that would have been considered at the PPO benefit level by the prior Claims Administrator but which are not considered at the PPO benefit level by the current Claims Administrator may be paid at the applicable PPO benefit level if the Covered Person is currently under a treatment plan by a Physician who was a member of this Plan's previous PPO but who is not a member of the Plan's current PPO in the Ordained Priest's network area. In order to ensure continuity of care for certain medical conditions already under treatment, the PPO medical plan benefit level may continue for 90 days for conditions approved as transitional care. Examples of medical conditions appropriate for consideration for transitional care include, but are not limited to:

- Cancer if under active treatment with chemotherapy and/or radiation therapy.
- Organ transplant patients if under active treatment (seeing a Physician on a regular basis, on a transplant waiting list, ready at any time for transplant).
- If the Covered Person is Inpatient in a Hospital on the effective date.
- Post acute Injury or Surgery within the past three months.
- Pregnancy in the second or third trimester and up to eight weeks postpartum.
- Behavioral Health – any previous treatment.

You must call UMR within 30 days prior to the effective date or within 30 days after the effective date to see if You are eligible for this benefit.

Routine procedures, treatment for stable chronic conditions, minor illnesses and elective surgical procedures will not be covered by transitional level benefits.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

1. **Allergy Treatment** including injections, testing and serum.
2. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically-appropriate Hospital.
3. **Anesthetics and Their Administration.**
4. **Aquatic Therapy** based on Medical Necessity. (See Therapy Services below.)
5. **Augmentation Communication Devices** and related instruction or therapy.
6. **Autism Spectrum Disorders (ASD) Treatment**, when Medical Necessity is met.

Treatment of Autism Spectrum Disorders, including Autism disorder, Asperger's Syndrome and pervasive development disorder not otherwise specified. Treatment includes intensive-level services and non-intensive-level services.

Intensive-level services means evidence-based behavioral therapies that are designed to help a Covered Person with autism spectrum disorder overcome the cognitive, social and behavioral deficits associated with that disorder.

Non-intensive-level services means evidence-based therapy that occurs after the completion of treatment for intensive-level services or, for a Covered Person who has not and will not receive intensive-level services, evidence-based therapy that will improve the Covered Person's condition.

Intensive-Level Services

Benefits are provided for evidence-based behavioral intensive-level therapy for a Covered Person with a verified diagnosis of autism spectrum disorder, the majority of which shall be provided to the Covered Person when the parent or legal guardian is present and engaged. The prescribed therapy must be consistent with all of the following requirements:

- Based upon a treatment plan developed by a Qualified practitioner that includes at least 20 hours per week over a six-month period of time of evidence-based behavioral intensive therapy, treatment and services with specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Covered Person be present and engaged in the intervention,
- Implemented by Qualified practitioners, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals,
- Provided in an environment most conducive to achieving the goals of the Covered Person's treatment plan,
- Included training and consultation, participation in team meetings and active involvement of the Covered Person's family and treatment team for implementation of the therapeutic goals developed by the team,
- Commenced after a Covered Person is two years of age and before nine years of age,
- The Covered Person is directly observed by the Qualified practitioner at least once every two months.

Intensive-level services will be covered for up to four cumulative years. Any previous intensive-level services received by the Covered Person, regardless of payor, may be applied to the required four years. The Plan may require documentation including medical records and treatment plans to verify any evidence-based behavioral therapy the Covered Person received for autism spectrum disorders prior to age nine.

Travel time for Qualified practitioners, supervising providers, professionals, therapists or paraprofessionals is not included when calculating the number of hours of care provided per week.

The Plan requires that progress be assessed and documented throughout the course of treatment. The Plan may request and review the Covered Person's treatment plan and the summary of progress on a periodic basis.

Non-Intensive Level Services

Non-intensive Level Services will be covered for a Covered Person with a verified diagnosis of autism spectrum disorder for non-intensive level services that are evidence-based and are provided to a Covered Person by a Qualified practitioner, professional, therapist or paraprofessional in either of the following conditions:

- After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level services treatment,
- To a Covered Person who has not and will not receive intensive-level services but for whom non-intensive level services will improve the Covered Person's condition.

Benefits will be provided for evidence-based therapy that is consistent with all of the following requirements:

- Based upon a treatment plan developed by a Qualified practitioner, supervising provider, professional or therapist that includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of autism spectrum disorders. Treatment plans shall require that the Covered Person be present and engaged in the intervention,
- Implemented by Qualified practitioners, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessional,
- Provided in an environment most conducive to achieving the goal of the Covered Person's treatment plan,
- Included training and consultation, participation in team meetings and active involvement of the Covered Person's family in order to implement the therapeutic goals developed by the team,
- Provided supervision of providers, professionals, therapists and paraprofessionals by qualified supervising providers on the treatment team.

Non-intensive level services may include direct or consultative services when provided by Qualified practitioners, qualified supervising providers, qualified professionals, qualified paraprofessionals or qualified therapists.

The Plan requires that progress be assessed and documented throughout the course of treatment. The Plan may request and review the Covered Person's treatment plan and the summary of progress on a periodic basis.

Travel time for Qualified practitioners, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals is not included when calculating the number of hours of care provided per week.

The Plan will notify the Covered Person (or their authorized representative) if the level of treatment is transitioning from intensive-level services to non-intensive-level services. The notice will indicate the reason for the transition that may include any of the following:

- The maximum four-year limit has been met,
- Intensive-level services are no longer supported by the documentation provided by the Qualified practitioner,
- The Covered Person no longer receives at least 20 hours per week of evidence-based behavioral therapy over a six-month period.

Intensive-level and non-intensive-level services include, but are not limited to speech, occupational and behavioral therapies.

The following services are not covered under the autism spectrum disorders:

- Acupuncture,
- Animal-based therapy, including hippotherapy,
- Auditory integration training,
- Chelation therapy,
- Cranial sacral therapy,
- Custodial or respite care,

- Hyperbaric oxygen therapy,
 - Special diets or supplements,
 - Pharmaceuticals and durable medical equipment.
7. **Breast Reductions** if Medically Necessary.
 8. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living (see the Glossary of Terms) and when needed as a result of an Illness or Injury.
 9. **Cardiac Rehabilitation** programs, if referred by a Physician, for patients who have:
 - Had a heart attack in the last 12 months; or
 - Had coronary bypass surgery; or
 - A stable angina pectoris.

Covered services include:

 - Phase I, while the Covered Person is an Inpatient.
 - Phase II, while the Covered Person is in a Physician-supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.
 10. **Cataract or Aphakia Surgery** as well as protective lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.
 11. **Cleft Palate And Cleft Lip**, including Medically Necessary oral surgery and pre-graft palatal expanders.
 12. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.
 13. **Dental Services** include:
 - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), excluding implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.
 - Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
 - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.
 14. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling.
 15. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. This also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as any other Illness.

16. **Durable Medical Equipment** subject to all of the following:
- The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
 - The equipment must be prescribed by a Physician.
 - The equipment is subject to review under the UMR CARE section of this SPD, if applicable.
 - The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
 - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
 - If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries, or replacement only if required:
 - When necessary because of a change in the Covered Person's physical condition; or
 - Because of deterioration caused from normal wear and tear.The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.
 - This Plan covers taxes, shipping and handling charges for Durable Medical Equipment.
17. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.
18. **Emergency Services Provided in a Foreign Country**, including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Inpatient or Outpatient basis at a Hospital or Physician services in a provider's office, as shown in the Schedule of Benefits.
19. **Extended Care Facility Services** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. Covered Person must obtain prior authorization for services in advance. (Refer to the UMR CARE section of this SPD). The following benefits are covered:
- Room and board.
 - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.
20. **Eye Refractions** if related to a covered medical condition.
21. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:
- Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
 - Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
 - Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.

22. **Genetic Counseling** based on Medical Necessity.
23. **Genetic Testing** when Medically Necessary (see below).
24. **Hearing Services** Hearing exams are covered only to test or treat hearing loss related to an Illness or Injury. A discount hearing program is available through EPIC Healthcare.
25. **Home Health Care Services:** (Refer to Home Health Care section of this SPD).
26. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:
- **Assessment** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
 - **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
 - **Outpatient Care** provides or arranges for other services as related to the Terminal Illness which include the services of a Physician or Qualified physical or occupational therapist, or nutrition counseling services provided by or under the supervision of a Qualified dietician.
 - **Respite Care** to provide temporary relief for 15 days inpatient and 15 days outpatient care to the family or other caregivers in the case of an emergency or to provide temporary relief from the daily demands of caring for a terminally ill person. Must be used in increments of not more than 5 days at a time.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

27. **Hospital Services (Includes Inpatient Services and Surgical Centers).** The following benefits are covered:
- Semi-private room and board. For network charges, this rate is based on network re-pricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate subject to Usual and Customary charges or the Negotiated Rate, whichever is applicable.
 - Intensive care unit room and board.
 - Miscellaneous and Ancillary Services.
 - Blood, blood plasma and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

28. **Hospital Services (Outpatient).**

Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

29. **Laboratory Or Pathology Tests And Interpretation Charges** for covered benefits.
30. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.
31. **Mental Health Treatment** (Refer to Mental Health section of this SPD).
32. **Modifiers or Reducing Modifiers** if Medically Necessary, apply to services and procedures performed on the same day and may be applied to surgical, radiology and other diagnostic procedures. For providers participating with a primary or secondary network, claims will be paid according to the network contract. For providers who are not participating with a network, where no discount is applied, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure and a percentage (%) of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.
33. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.
- Bariatric surgery, including, but not limited to:
 - Gastric or intestinal bypasses (Roux-en-Y, biliopancreatic bypass, biliopancreatic diversion with duodenal switch).
 - Stomach stapling (vertical banded gastroplasty, gastric banding, gastric stapling).
 - Lap band (laparoscopic adjustable gastric banding).
 - Gastric sleeve procedure (laparoscopic vertical gastrectomy, laparoscopic sleeve gastrectomy).
 - Charges for diagnostic services.
 - Nutritional counseling by a registered dietitian.
- This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions of this SPD.
34. **Nutritional Counseling** if Medically Necessary.
35. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and administered through enteral feedings, provided they are the sole source of nutrition. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings) provided the feedings are prescribed by a Physician, and are the sole source of nutrition.
36. **Occupational Therapy.** (See Therapy Services below)
37. **Oral Surgery** includes:
- Excision of partially or completely impacted teeth if hospitalization is required because of a hazardous medical condition (e.g. hemophilia).
 - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
 - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 - Reduction of fractures and dislocations of the jaw.
 - External incision and drainage of cellulitis.
 - Incision of accessory sinuses, salivary glands or ducts.
 - Excision of exostosis of jaws and hard palate.

38. **Orthotic Appliances, Devices and Casts**, including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include supports, trusses, elastic compression stockings, and braces.
39. **Oxygen And Its Administration.**
40. **Pharmacological Medical Case Management** (Medication management and lab charges).
41. **Physical Therapy.** (See Therapy Services below)
42. **Physician Services** for covered benefits.
43. **Pre-Admission Testing:** The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.
44. **Prescription Medications** which are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or Skilled Nursing Facility) and that require a Physician's Prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.
45. **Preventive / Routine Care** as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility or a Hospital that 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 the 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
- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Please visit the following links for additional information:

<https://www.healthcare.gov/preventive-care-benefits/>

46. **Private Duty Nursing Services** when Outpatient care is required 24 hours a day for home health care only. This does not include Inpatient private duty nursing services.
47. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:
- When necessary because of a change in the Covered Person's physical condition; or
 - Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

48. **Qualifying Clinical Trials** as defined below, including 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.

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 may include:

- Covered health services (i.e., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial.
- 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 consistent 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 that 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)*, including the *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 *Veteran's 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:
 - It is comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
 - It 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. The Plan Sponsor 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.

49. **Radiation Therapy and Chemotherapy.**

50. **Radiology and Interpretation Charges.**

51. **Reconstructive Surgery** includes:

- Following a mastectomy (Women's Health and Cancer Rights Act) the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include 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 complications of mastectomies, including lymphedemas.
- Surgery to restore bodily function that has been impaired by a congenital illness or anomaly, or by an Accident, or from an infection or other disease of the involved part.

52. **Respiratory Therapy.** (See Therapy Services below)

53. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

54. **Sleep Disorders** if Medically Necessary.

55. **Sleep Studies.**

56. **Speech Therapy.** (See Therapy Services below)

57. **Substance Use Disorder Services** (Refer to Substance Use Disorder section of this SPD).

58. **Surgery and Assistant Surgeon Services** (See Modifiers or Reducing Modifiers above).

59. **Telemedicine - Telephone or Internet Consultations:** Consultations made by a Covered Person to a Physician.

60. **Temporomandibular Joint Disorder (TMJ) Services** includes:

- Diagnostic services.
- Surgical treatment.
- Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

This does not cover orthodontic services.

61. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Any therapy beyond 25 visits in a calendar year will be reviewed for Medical Necessity. Services include:

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory therapy** by a Qualified respiratory therapist (RT), or other Qualified Provider, if applicable.
- **Aquatic therapy** by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or Autism Spectrum Disorder.

The Plan allows coverage for occupational and/or physical therapy for Developmental Delays due to Accidents or Illnesses such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome, and cerebral palsy when performed by a Qualified Provider. The Plan allows coverage for the treatment of disorders of speech, language, voice, communication, and auditory processing only when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or Autism Spectrum Disorder. The Plan will pay benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular Accident.

62. **Tobacco Addiction:** Services, treatment or supplies related to addiction to or dependency on nicotine.

63. **Transplant Services** (Refer to Transplant section of this SPD).

64. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

65. **X-ray Services** for covered benefits.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary, as determined by the Utilization Review Organization.

Prior authorization may be required before receiving services. Please refer to the UMR CARE section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the Usual and Customary charge for the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician, or other Qualified Provider, if applicable.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a Qualified therapist, or other Qualified Provider, if applicable.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services (each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer to the UMR CARE section of this SPD for prior authorization requirements

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing and Ancillary Services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T).

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan's Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior authorization for all transplant related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor related complications during the transplant period, as per the transplant contract, if the recipient is a Covered Person under this Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by CARE (Care Management).
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous) for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by transplant facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS (Applies to a Designated Transplant Facility Only)

TRAVEL EXPENSES (Applies to a Covered Person who is a recipient or to a covered or non-covered donor if the recipient is a Covered Person under this Plan)

If the Covered Person or non-covered living donor lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:
 - Airfare.
 - Tolls and parking fees.
 - Gas/mileage.
- Lodging at or near the transplant facility including:
 - Apartment rental.
 - Hotel rental.
 - Applicable tax.

Lodging for purposes of this Plan does not include private residences.

Lodging reimbursement that is greater than \$50 per person per day, may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

Note: This Plan will only pay travel and housing benefits for a non-covered living donor after any other coverage that the living donor has is exhausted.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational or Unproven unless covered under a Qualifying Clinical Trial.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS
Administered by MedOne Healthcare Systems

NOTE: UMR (the claims administrator) does not administer the benefits within this provision. Please contact the Benefit Manager or Your employer with any questions related to this coverage.

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare-eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare-eligible individuals generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to obtain Prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay an additional monthly penalty if they change their mind and sign up later. Medicare-eligible individuals should have received a Notice informing them whether their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

HEARING AID BENEFITS

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by UnitedHealthcare Hearing.

UnitedHealthcare Hearing provides a full range of hearing health benefits that deliver value, choice, and a positive experience.

UnitedHealthcare Hearing offers:

- Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
- Access to a network of credentialed hearing professionals at more than 5,000 locations nationwide.
- Convenient ordering with hearing aids available in person or through home delivery.

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-855-523-9355, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhchearing.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- Receive a hearing test by a UnitedHealthcare Hearing provider. During the appointment, You will decide if You would like to have Your hearing aids fitted in person with Your hearing provider or to have Your hearing aids delivered directly to Your home (for select hearing aid models only). A broad selection of name-brand and private-labeled hearing aids is available.
- If You choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered by the provider and sent directly to the provider's office. You will be fitted with the hearing aid(s) by the local provider. If You choose home delivery, the hearing aids will be sent directly to Your home within 5-10 business days from the order date.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-855-523-9355 or visit uhchearing.com.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide “residential” treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions or substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person’s condition is not being provided.
- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.
- Services provided for conflict between the Covered Person and society that is solely related to criminal activity.

- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the International Classification of Diseases - Clinical Modification (ICD-CM) manual (most recent revision) in the following categories:
 - Sexual/gender identity disorders; or
 - Behavior and impulse control disorders; or
 - “V” codes (including marriage counseling).
- Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, the Usual and Customary amount, or the Negotiated Rate as applicable.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a sub-acute facility-based program that is licensed to provide “residential” treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions or substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person’s condition is not being provided.

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

Utilization Management

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and the appropriate level of care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons are responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact-gathering and independent medical review, if necessary.

Special Notes: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. Covered Persons who have received care on this basis are responsible for ensuring the provider contacts the Utilization Review Organization (see below) as soon as possible by phone or fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

The following terms are used for the purpose of the UMR CARE section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called "utilization review." Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, over \$1,500 or Durable Medical Equipment rentals over \$500 per month.
- Prosthetics over \$1,000.
- Qualifying Clinical Trials.
- Medical Specialty Medications / Injectables Program (including select gene therapy drugs, orphan drugs, and CAR-T drugs) covered under the medical Plan, including Site of Care when applicable. Please visit <https://fhs.umar.com/print/UM1428.pdf> for a list of Medical Specialty Medications. To request a copy of the Medical Specialty Medications list, call the toll-free number on the back of Your member identification card and the list will be provided free of charge.
- Private Duty Nursing.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty of 50% up to a maximum \$500 may be applied to applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization.

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization.

Medical Director Oversight. A UMR CARE medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Opportunities are identified by using system-integrated, automated, and manual trigger lists during the Prior Authorization review process. Other trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals.

Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures and a final determination will be made no later than 30 days after the request for review.

Complex Condition CARE

Complex Condition CARE is available to all Covered Persons. CARE nurse managers evaluate and coordinate post-hospitalization needs for members who have a high probability of subsequent readmission within 30 days. Participants are identified based on historical claim factors and current admission information, including, but not limited to:

- unplanned readmission within the past 30 days or multiple unplanned admissions within the past 6 months.
- length of stay.
- complex diagnoses or comorbidities pertaining to cardiovascular conditions, kidney failure, pulmonary conditions or infections, or liver/pancreas/gastrointestinal surgery.

CENTERS OF EXCELLENCE

Kidney Resource Services (KRS)

Kidney Resource Services (KRS) provides access to a preferred provider dialysis network and support from a UMR CARE Nurse Manager by collaborating with the Covered Person to delay the progression of the disease to renal failure.

UMR CARE End-Stage Renal Disease (ESRD) specialty nurses focus on clinical support and treatments.

If a Covered Person chooses to seek services at a KRS preferred provider, the Covered Person must contact UMR CARE at 866-494-4502.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (which is Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. If the covered benefit under this Plan is less than or equal to the Primary Plan's payment, then no payment is made by this Plan.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of \$200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies. See order of benefit determination rules (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

This Plan does not, however, coordinate benefits with individual health and dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.
- When medical payments are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.
- Active or Inactive Ordained Priest: If an individual is covered under one plan as an active Ordained Priest, and is also covered under another plan as a retired or laid off Ordained Priest, the plan that covers the person as an active Ordained Priest will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under State Law: If a person has elected continuation of coverage under state law, and also has coverage under another plan, the continuation coverage is secondary. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies.
- Longer or Shorter Length of Coverage: The plan that covered the person as an Ordained Priest, member, subscriber or the retiree the longest is primary.
- If an active Ordained Priest is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Ordained Priest, member, or subscriber is considered primary.
- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You are receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (which is Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. If the covered benefit under this Plan is less than or equal to the Primary Plan's payment, then no payment is made by this Plan.

When this Plan is not Primary and a Covered Person is receiving Medicare Part A but has chosen not to elect Medicare Part B, this Plan will reduce its payments on Medicare Part B services as though Medicare Part B was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
 - You continue to be actively employed by the employer and You become eligible for and enrolls in Medicare because of age or disability.
 - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. At the end of the 30-month period, Medicare becomes the primary payer.

- Medicare generally pays first under the following circumstances:
 - You are no longer actively employed by an employer; and
 - You have Medicare coverage due to age; or
 - You or a covered family member has Medicare coverage based on a disability; or
 - You have retiree coverage plus Medicare coverage; or
 - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability **before** being diagnosed with ESRD and Medicare was previously paying as the primary plan, then the person may continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

Note: If a Covered Person is eligible for Medicare as his or her primary plan, all benefits from this Plan will be reduced by the amount Medicare would pay, regardless of whether or not the Covered Person is enrolled in Medicare.

TRICARE

If an eligible Ordained Priest is on active military duty, TRICARE is the only coverage available to that Ordained Priest. Benefits are not coordinated with the Ordained Priest's health insurance plan.

In all instances where an eligible Ordained Priest is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any third party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will 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 Illness or Injury for which any third party is considered responsible.

The right to reimbursement means that if it is alleged that any third party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive for that Illness or Injury. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers’ Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners’, or otherwise), Workers’ Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any third party.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan’s legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that 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 our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or Injuries.
 - Making court appearances.
 - Obtaining our consent or our agents’ consent before releasing any party from liability or payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness 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 that 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, our 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, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will 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 will limit our 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 Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.
- By participating in and accepting benefits from the Plan, You agree that:
 - Any amounts recovered by You from any third party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
 - You and Your representative will be fiduciaries of the Plan (within the meaning of ERISA) with respect to such amounts; and
 - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.
- 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 Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party; filing an ERISA reimbursement lawsuit to recover the full amount of medical benefits You receive for the Illness or Injury out of any settlement, judgment, or other recovery from any third party considered responsible; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain. Any ERISA reimbursement lawsuit stemming from a refusal to refund benefits as required under the terms of the Plan is governed by a six-year statute of limitations.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.
- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will 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 an Illness or Injury caused by any third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If any third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.
- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; 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 Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of 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.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions based upon the source of the Injury to treatment listed in the Covered Medical Benefits section when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or a victim of an act of domestic violence.

1. **Abdominoplasty.**
2. **Acts Of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
3. **Acupuncture Treatment.**
4. **Alternative / Complementary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.
5. **Appointments Missed:** An appointment the Covered Person did not attend.
6. **Aquatic Therapy** unless provided by a Qualified physical therapist (PT), Qualified aquatic therapist (AT), or other Qualified Provider, if applicable.
7. **Assistance With Activities of Daily Living.**
8. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.
9. **Auto Excess:** Illness or bodily Injury for which there is a medical payment or expense coverage provided or payable under any automobile coverage.
10. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.
11. **Bereavement Counseling.**
12. **Biofeedback Services.**
13. **Blood:** Blood donor expenses.
14. **Blood Pressure Cuffs / Monitors.**
15. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.
16. **Chelation Therapy**, except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.
17. **Claims** received later than 12 months from the date of service.
18. **Cosmetic Treatment, Cosmetic Surgery**, or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

19. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.
20. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this criminal activity took place.
21. **Custodial Care** as defined in the Glossary of Terms of this SPD.
22. **Custom-Molded Shoe Inserts**, including the exam for required Prescription and fitting.
23. **Dental Services**, unless covered elsewhere in this SPD.
24. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.
25. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.
26. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.
27. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.
28. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.
29. **Experimental, Investigational or Unproven:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental, Investigational or Unproven, including administrative services associated with Experimental, Investigational or Unproven treatment. This does not include Qualifying Clinical Trials as described in the Covered Benefits section of this SPD.
30. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.
31. **Financial Counseling.**
32. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.
33. **Foot Care (Podiatry):** Routine foot care.
34. **Genetic Counseling** other than based on Medical Necessity unless covered elsewhere in this SPD.
35. **Genetic Testing** unless covered elsewhere in this SPD.
36. **Growth Hormones.**
37. **Hearing Services:**
 - Purchase or fitting of hearing aids.
 - Implantable hearing devices unless covered elsewhere in this SPD.

38. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.
39. **Infertility Treatment:**
- Fertility tests.
 - Surgical reversal of a sterilized state which was a result of a previous surgery.
 - Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
 - Artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
 - Embryo transfer.
 - Freezing or storage of embryo, eggs, or semen.
 - Genetic testing.
- This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition, slow the harm to, alleviate the symptoms, or maintain the current health status of the Covered person.
40. **Liposuction** regardless of purpose.
41. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.
42. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this SPD.
43. **Marriage Counseling.**
44. **Massage Therapy.**
45. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.
46. **Military:** A military related Illness or Injury to a Covered Person on active military duty, unless payment is legally required.
47. **Nocturnal Enuresis Alarm** (Bed wetting).
48. **Non-Custom-Molded Shoe Inserts.**
49. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.
50. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities or equipment which reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy, above.
51. **Nutrition Counseling** unless covered elsewhere in this SPD.
52. **Nutritional Supplements, Vitamins and Electrolytes** except as listed under the Covered Benefits.
53. **Orthognathic, Prognathic and Maxillofacial Surgery.**

- 54. **Over-The-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this SPD.
- 55. **Palliative Foot Care.**
- 56. **Panniculectomy** unless determined by the Plan to be Medically Necessary.
- 57. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.
- 58. **Pharmacy Consultations.** Charges for or relating to consultative information provided by a pharmacist regarding a prescription order, including but not limited to information relating to dosage instruction, drug interactions, side effects, and the like.
- 59. **Preventive / Routine Care Services** unless covered elsewhere in this SPD.
- 60. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.
- 61. **Return to Work / School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.
- 62. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.
- 63. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.
- 64. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.
- 65. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.
- 66. **Services** that should legally be provided by a school.
- 67. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.
- 68. **Sex Therapy.**
- 69. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.
- 70. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.
- 71. **Standby Surgeon Charges.**
- 72. **Sterilizations (Voluntary).**
- 73. **Subrogation.** Charges for Illness or Injuries suffered by a Covered Person due to the action or inaction of any third party if the Covered Person fails to provide information as specified in the Subrogation section. See the Subrogation section for more information.

- 74. **Surrogate Parenting and Gestational Carrier Services**, including any services or supplies provided in connection with a surrogate parent, including pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate parent.
- 75. **Taxes:** Sales taxes, shipping and handling unless covered elsewhere in this SPD.
- 76. **Telehealth.** Consultations made by a Covered Person's treating Physician to another Physician.
- 77. **Telemedicine.**
- 78. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.
- 79. **Travel:** Travel costs, unless covered elsewhere in this SPD.
- 80. **Vision Care** unless covered elsewhere in this SPD.
- 81. **Vitamins, Minerals and Supplements**, even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician for Medically Necessary purposes.
- 82. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.
- 83. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency.
- 84. **Weight Control:** Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This does not include specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.
- 85. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving**, or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.
- 86. **Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit including self-employment, for which the Covered Person is entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, where required by state law. This exclusion does not apply to any Ordained Priest while working for the Archdiocese of Dubuque.
- 87. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the Claims Administrator, on behalf of the Plan, prior to services being provided. Although not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. A Covered Person or provider may wish to request a Pre-Determination before incurring medical expenses. A Pre-Determination is not a claim and therefore cannot be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan **before** obtaining the medical care such as in the case of prior authorization of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization (See Pre-Determination above). The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

Note: This Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the UMR CARE section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.
- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, Social Security number, address, and relationship to Ordained Priest
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient account number (if applicable)
- Total billed charges
- Provider billing name, address, telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all of the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly follow the Plan's procedures for requesting prior authorization, the Plan will notify the person and explain the proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to an established fee schedule, according to a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, a provider is paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's allowable charge used in the calculation of the payable benefit.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Usual and Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. Refer to the U&C level being allowed by the Centers for Medicare and Medicaid Services on the Provider Network provision, see surgery and assistant surgeon under the Covered Benefits for exceptions related to multiple procedures. As it relates to charges made by a network provider, the term Usual and Customary means the Negotiated Rate as contractually agreed to by the provider and network (see above). A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your Plan Administrator or amounts permitted by law. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Co-pays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- **Pre-Service Claim:** A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- **Post-Service Claims:** Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- **Concurrent Care Claims:** If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- **Emergency and/or Urgent Care Claim:** The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.
- Termination of the group health Plan.
- The Ordained Priest or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Ordained Priest is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, the fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume that the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records and other information relating to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or a victim of an act of domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This will include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, the experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.

- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the “Adverse Benefit Determination” section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 60 calendar days following the date he or she received the Plan’s decision regarding the first appeal. The Plan will assume that the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or a victim of an act of domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, the experts will be identified upon the Covered Person’s request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the “Adverse Benefit Determination” section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person’s decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal including applicable rules, a Covered Person’s right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan. Refer to the Statement of ERISA Rights section of this SPD for details on a Covered Person’s additional rights to challenge the benefit decision under Section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to the following address(es):

Send Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

This Plan contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made should send appeals directly to the company that made the decision being appealed. This includes the RIGHT TO EXTERNAL REVIEW.

Send Pharmacy appeals to:
MedOne
703 MAIN ST STE C
DUBUQUE IA 52001

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where we are unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the adverse benefit determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven Services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a wellness program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits); or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the time lines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR or Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request to the following address:

UMR
EXTERNAL REVIEW
APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Ordained Priest's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within four months of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the Claims Administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, a Covered Person has the right to further appeal an Adverse Benefit Determination by bringing a civil action under the Ordained Priest Retirement Income Security Act (ERISA). Please refer to the Statement of ERISA Rights section of this SPD for more details. **No such action may be filed against the Plan later than three years from the date the Plan gives the Covered Person a final determination on his or her appeal.**

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive. (Please note that the examples listed are not all-inclusive).

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else - files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Ordained Priest is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Ordained Priest has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal FMLA and any amendment; or
- The leave period required by applicable state law.

An Ordained Priest may choose not to retain group health coverage during an FMLA leave. When the Ordained Priest returns to work following the FMLA leave, the Ordained Priest's coverage will usually be restored to the level the Ordained Priest would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Ordained Priest Retirement Income Security Act regarding coverage of Dependent Children in cases of adoption or Placement for Adoption.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;
- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Ordained Priest benefit plans;
- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;
- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;
- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and
- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Ordained Priests, classes of Ordained Priests, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Human Resources Benefit Specialist, Director of Human Resources

This list includes every Ordained Priest, class of Ordained Priests, or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Ordained Priests or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Ordained Priests or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health or condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your employer.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

STATEMENT OF ERISA RIGHTS

Under the Ordained Priest Retirement Income Security Act of 1974 (ERISA), all Covered Persons will have the right to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Ordained Priest Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.
- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS' RIGHTS

If a claim for a benefit is denied or ignored, in whole or in part, Covered Persons have a right to know why this was done, to obtain copies of documents related to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an Ordained Priest can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within 30 days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to \$110 per day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If You have any questions about this Plan, contact the Plan Administrator. If You have any questions about this statement or about a Covered Person's rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Ordained Priest Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Ordained Priest Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Ordained Priest Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Post tax contributions paid by Retirees, if applicable, will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and will not inure to the benefit of the employer.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, to treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means 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 services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation, or when Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency, including the following: ambulance services, anesthesiology, assistant surgeon services, pathology, and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Close Relative means a member of the immediate family. Immediate family includes the Ordained Priest, mother, father, grandmother, grandfather, step-parents, step-grandparents, siblings, step-siblings, and half-siblings.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan.

Covered Person means an Ordained Priest who is enrolled under this Plan.

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means the amount of Covered Expenses that must be paid by the Covered Person before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Developmental Delays may not necessarily have a history of birth trauma or other Illness that could be causing the impairment, such as a hearing problem, mental Illness, or other neurological symptoms or Illness.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It generally is not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that a Prudent Layperson would seek immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins.
- For anyone who enrolls for Late Enrollees, the first day coverage begins.

ERISA means the Ordained Priest Retirement Income Security Act of 1974, as amended from time to time, and applicable regulations.

Essential Health Benefit means any medical expense that falls under the following categories, as defined 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, if applicable.

Experimental, Investigational or Unproven means any drug, service, supply, care or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;
- Items based on anecdotal and Unproven evidence (literature consists only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provides the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law prohibits discrimination and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; Physician services; physical or occupational therapy; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating;
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers licensed by the state in which they operate. The term "Hospital" does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness or functional nervous disorder,

Incurred means the date on which a service or treatment is given, a supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor or an entity or individual who performs services to or on behalf of the employer who is not an Ordained Priest or an officer of the employer and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section § 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on the earliest date on which coverage can become effective under the terms of this Plan.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Condition means a disease or condition likely to cause death within one year of the request for treatment.

Maximum Benefit means the maximum amount or the maximum number or days or treatments that are considered a Covered Expense by the Plan.

Medical Specialty Medications / Injectables (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for Your illness, injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, disease, or symptoms; and

- Clinical factors used when reviewing Medical Necessity for specialty drugs may include review of the progress in use or therapy as compared to other similar products or services, Site of Care, relative safety or effectiveness of specialty drugs, and any applicable prior authorization requirements.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

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. We reserve 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, will be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Mental Health Disorder means a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for mental functioning.

Morbid Obesity means a condition in which an individual 18 years of age or older has a Body Mass Index (BMI) of 40 or more, or 35 or more if experiencing health conditions directly related to his or her weight, such as high blood pressure, diabetes, sleep apnea, etc.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefit means any medical benefit that is not an Essential Health Benefit. Please refer to the "Essential Health Benefit" definition.

Ordained Priest – see the Eligibility and Enrollment section of this SPD.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances means a brace, a splint, a cast and other appliance that is used to support or restrain a weak or deformed part of the body that is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and that is generally not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: a doctor of medicine (MD), doctor of medical dentistry including an oral surgeon (DMD), doctor of osteopathy (DO), doctor of podiatric medicine (DPM), doctor of dental surgery (DDS), doctor of chiropractic (DC), doctor of optometry (OPT). Subject to the limitations below, the term "Physician" shall also include the following practitioner types: nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Plan means the PRIESTS OF THE ARCHDIOCESE OF DUBUQUE Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive/Routine is based upon the recommendations of the Center for Disease Control and Prevention. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Qualified means licensed, registered, and/or certified in accordance with the applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Site of Care means the treatment location where services are rendered, for example, Outpatient Hospital, community office, ambulatory infusion site, or home-based settings.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Ordained Priest is prevented from engaging in any job or occupation for wage or profit for which the Ordained Priest is Qualified by education, training or experience; or
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) or the most recent revision of the International Classification of Disease – Clinical Modification manual (ICD-CM) in the following categories:
 - Sexual/gender identity disorders; or
 - Behavior and impulse control disorders; or
 - “V” codes.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

You / Your means the Ordained Priest.