UNIVERSITY OF SOUTHERN INDIANA
EVANSVILLE IN

Health Benefit Summary Plan Description
7670-00-416553

BENEFITS ADMINISTERED BY

PLAN INFORMATION

Plan Name	UNIVERSITY OF SOUTHERN INDIANA GROUP HEALTH BENEFIT PLAN
Name And Address Of Employer	UNIVERSITY OF SOUTHERN INDIANA 8600 UNIVERSITY BLVD EVANSVILLE IN 47712
Name, Address, And Phone Number Of Plan Administrator	UNIVERSITY OF SOUTHERN INDIANA 8600 UNIVERSITY BLVD EVANSVILLE IN 47712 812-464-1790
Named Fiduciary	UNIVERSITY OF SOUTHERN INDIANA
Claims Appeal Fiduciary For Medical Claims	UMR
Employer Identification Number Assigned By The IRS	35-1308176
Plan Number Assigned By The Plan	501
Type Of Benefit Plan Provided	Self-funded Health and 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	UNIVERSITY OF SOUTHERN INDIANA 8600 UNIVERSITY BLVD EVANSVILLE IN 47712
Funding Of The Plan	Employer and Employee 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 Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.

Compliance

It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.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.

	IN-NETWORK	OUT-OF-NETWORK
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:		
x Paid By Plan After Deductible	80%	60%
Preventive / Routine Pelvic Exams And Pap Tests:		

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
In Addition, The Following Preventive / Routine Services Are Covered For Women: ¾ **Screening For Gestational Diabetes** ¾ **Papillomavirus DNA Testing*** ¾ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ¾ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ¾ **Breastfeeding Support, Supplies, And Counseling** ¾ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)***		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
***These Services May Also Apply To Men.**		
Preventive / Routine Care Benefits For Children Include:		
Preventive / Routine Physical Exams:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Immunizations:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Screenings At Appropriate Ages:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Diagnostic Tests, Lab, And X-Rays:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Hearing Exams:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Eye Exams:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Eye Refractions:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Private Duty Nursing:		
x Maximum Visits Per Calendar Year	82 Visits	
x Maximum Visits Per Lifetime	164 Visits	
x Paid By Plan After Deductible	80%	60%
Sterilizations:		
For Men:		
x Paid By Plan After Deductible	80%	60%
For Women:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Teladoc Services:		
General Medicine:		
x Copay Per Occurrence	$15	
x Paid By Plan	100% (Deductible Waived)	
Dermatology:		
x Copay Per Occurrence	$15	
x Paid By Plan	100% (Deductible Waived)	
Note: Multiple Copays Apply When Multiple Claims Are Billed On The Same Date Of Service.		
Telehealth:		
x Copay Per Visit	$30	Not Applicable
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Temporomandibular Joint Disorder Benefits:		
x Paid By Plan After Deductible	80%	60%
Therapy Services:		
Occupational Outpatient Hospital And Office Therapy:		
x Maximum Visits Per Calendar Year	60 Visits	
Occupational Outpatient Hospital Therapy:		
x Paid By Plan After Deductible	80%	60%
Occupational Office Therapy:		
x Copay Per Visit	$30	Not Applicable
x Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Expanded Preventive List For Specific Chronic Conditions - Refer To The Covered Medical Benefits Section For Details:		
Antiresorptive Therapy For The Diagnosis Of Osteoporosis And / Or Osteopenia:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Beta-Blockers For The Diagnosis Of Congestive Heart Failure:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Home Health Care Benefits: x Paid By Plan After Deductible ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.***	80%	60%
Hospice Care Benefits: **Hospice Services:** x Paid By Plan After In-Network Deductible	80%	80%

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	IN-NETWORK	OUT-OF-NETWORK
Manipulations:		
x Maximum Visits Per Calendar Year	12 Visits	
x Paid By Plan After Deductible	80%	60%

Visit Maximums Are Applied Based On Provider Designation And Procedure Code.

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Mammograms And Breast Exams:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:		
x Paid By Plan After Deductible	80%	60%
Preventive / Routine Pelvic Exams And Pap Tests:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine PSA Test And Prostate Exams:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:		
x Paid By Plan After Deductible	[redacted]	60%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Eye Exams:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Eye Refractions:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Private Duty Nursing:		
x Maximum Visits Per Calendar Year	82 Visits	
x Maximum Visits Per Lifetime	164 Visits	
x Paid By Plan After Deductible	80%	60%
Sterilizations:		

For Men:

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 003

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

Benefits listed in this Schedule of 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, 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 Excluding The Prescription Benefit Deductible:		

	IN-NETWORK	OUT-OF-NETWORK
Ambulance Transportation: x Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Breast Pumps: x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Cardiac Pulmonary Rehabilitation: **Outpatient Hospital Setting:** x Paid By Plan After Deductible **Office Setting:** x Copay Per Visit x Paid By Plan After Deductible	 80% $20 100% (Deductible Waived)	 60% Not Applicable 60%
Cardiac Rehabilitation Phase 1 & 2: **Outpatient Hospital Setting:** x Paid By Plan After Deductible **Office Setting:** x Copay Per Visit x Paid By Plan After Deductible	 80% $20 100% (Deductible Waived)	 60% Not Applicable 60%
Contraceptive Methods And Contraceptive		

	IN-NETWORK	OUT-OF-NETWORK
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:		
x Paid By Plan After Deductible	80%	60%
Home Health Care Benefits:		
x Paid By Plan After Deductible	80%	60%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.		
Hospice Care Benefits:		
Hospice Services:		
x Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Bereavement Counseling:		
x Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Respite Care:		
x Maximum Benefit	8 Hour(s) Per Week	
x Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Hospital Services:		
Pre-Admission Testing:		
x Paid By Plan After Deductible	80%	60%
Inpatient Services / Inpatient Physician Charges; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
x Paid By Plan After Deductible	80%	60%
Outpatient Services / Outpatient Physician Charges:		
x Paid By Plan After Deductible	80%	60%
Outpatient Advanced Imaging Charges:		
x Paid By Plan After Deductible	80%	60%
Outpatient Lab And X-Ray Charges:		

	IN-NETWORK	OUT-OF-NETWORK

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ¾ **Preventive / Routine Services** ¾ **Manipulation Services Billed By Any Qualifying Provider** ¾ **Dental Services Billed By Any Qualifying Provider** ¾		

	IN-NETWORK	OUT-OF-NETWORK
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:		
x Paid By Plan After Deductible	80%	60%
Preventive / Routine Pelvic Exams And Pap Tests:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine PSA Test And Prostate Exams:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Colonoscopies, Sigmoidoscopies, And Similar Routine Surgical Procedures Performed For Preventive Reasons:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Hearing Exams:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Preventive / Routine Eye Exams And Glaucoma Testing:		
x Maximum Exams Per Calendar Year	1 Exam	

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition: x Paid By Plan After Deductible	100% (Deductible Waived)	60%
In Addition, The Following Preventive / Routine Services Are Covered For Women: ¾ **Screening For Gestational Diabetes** ¾ **Papillomavirus DNA Testing*** ¾ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ¾ **Counseling For Human Immune-Deficiency Virus (Provided Annually)***		

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Eye Exams:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Eye Refractions:		
x Maximum Exams Per Calendar Year	1 Exam	
x Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Private Duty Nursing:		
x Maximum Visits Per Calendar Year	82 Visits	
x Maximum Visits Per Lifetime	164 Visits	
x Paid By Plan After Deductible	80%	60%
Sterilizations:		
For Men:		
x Paid By Plan After Deductible	80%	60%
For Women:		
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Teladoc Services:		
General Medicine:		
x Copay Per Occurrence	$15	
x Paid By Plan	100% (Deductible Waived)	
Dermatology:		
x Copay Per Occurrence	$15	
x Paid By Plan	100% (Deductible Waived)	
Note: Multiple Copays Apply When Multiple Claims Are Billed On The Same Date Of Service.		
Telehealth:		
x Copay Per Visit	$20	Not Applicable
x Paid By Plan After Deductible	100% (Deductible Waived)	60%
Temporomandibular Joint Disorder Benefits:		
x Paid By Plan After Deductible	80%	60%
Therapy Services:		
Occupational Outpatient Hospital And Office Therapy:		
x Maximum Visits Per Calendar Year	90 Visits	
Occupational Outpatient Hospital Therapy:		
x Paid By Plan After Deductible	80%	60%
Occupational Office Therapy:		
x Copay Per Visit	$20	Not Applicable
x Paid By Plan After Deductible	100% (Deductible Waived)	60%

	IN-NETWORK	OUT-OF-NETWORK
Physical Outpatient Hospital And Office Therapy: x Maximum Visits Per Calendar Year	90 Visits	
Physical Outpatient Hospital Therapy: x Paid By Plan After Deductible	80%	60%
Physical Office Therapy: x Copay Per Visit		

TRANSPLANT SCHEDULE OF BENEFITS

The program for Transplant Services at Designated Transplant Facilities is:

Optum

Benefit Plan(s) 001

Transplant Services: Designated Transplant Facility		
Transplant Services: x Paid By Plan After Deductible	80%	
Travel And Housing: x Maximum Benefit Per Transplant x 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.		
	IN-NETWORK	**OUT-OF-NETWORK**
Transplant Services: Non-Designated Transplant Facility		

Transplant Services:/F2 9.96 Tf1 0 0 1 378.55 478.27*a*

TRANSPLANT SCHEDULE OF BENEFITS The program for Transplant Services at Designated Transplant Facilities is: Optum Benefit Plan(s) 002	
Transplant Services: Designated Transplant Facility	
Transplant Services: x Paid By Plan After Deductible	80%
Travel And Housing: x Maximum Benefit Per Transplant x Paid By Plan After Deductible	$10,000 100%

TRANSPLANT SCHEDULE OF BENEFITS

The program for Transplant Services at Designated Transplant Facilities is:

Optum

Benefit Plan(s) 003

Transplant Services: Designated Transplant Facility **Transplant Services:** x Paid By Plan After Deductible **Travel And Housing:** x Maximum Benefit Per Transplant x Paid By Plan Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	80% $10,000 100% (Deductible Waived)	
	IN-NETWORK	**OUT-OF-NETWORK**
Transplant Services: Non-Designated Transplant Facility **Transplant Services:** x Paid By Plan After Deductible **Donor Services**:	80%	60%
x Maximum Benefit Per Transplant	$30,000	
x Paid By Plan After Deductible **Travel And Housing:**	80%	60% No Benefit
x Maximum Benefit Per Transplant	$10,000	
x Paid By Plan	100% (Deductible Waived)	

OUT-OF-POCKET EXPENSES AND MAXIMUMS

Benefit Plan(s) 001, 003

COPAYS

A Copay is the amount that the Covered Person pays each time certain services are received. The Copay is typically a flat dollar amount and is paid at the time of service or when billed by the provider. Copays do not apply toward satisfaction of Deductibles. Copays apply toward satisfaction of in-network and out-of-network out-of-pocket maximums. The Copay and out-of-pocket maximum are shown on the Schedule of Benefits.

DEDUCTIBLES

A Deductible is an amount of money paid once per Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. 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 an in-network provider will apply to the in-network total individual and family Deductible. The Deductible amounts that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total individual and family Deductible.

PLAN PARTICIPATION

Plan Participation is the percentage of Covered Expenses that the Covered Person is responsible for SD\LQJ DIWHU WKH 'HGXFWLEOH LV PHW 7KH &RYHUHG 3HUVRQ SD\V W RU IDPLO\¶V LI DSSOLFDEOH out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits.

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ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. There are separate in-network and out-of-network out-of-pocket maximums for this Plan. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covere G ([SHQVHV ZLOO EH XVHG WR VDWLVI\ WKH &RYHUHG 3HUVRQ annual out-of- SRFNHW PD[LPXP V ,I WKH out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of the Covered Expenses through the end of the Plan Year.

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.
- Pharmacy out-of-network Copays and out-of-network Plan Participation amounts for Prescription benefits.
- Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on his or her 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

The Dependent Child must also fit the following category:

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of the following dates:

x The date Your coverage under the Plan begins ic4 688.42 Tm0 g0 G[3078]TJETQq0.00000912 0 612 792 reW*ne Your

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives an eligible person special enrollment rights if the person experiences a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

Note: Retirees are not eligible for special enrollment due to loss of other coverage. Similarly, Retirees who are not currently participating in the Plan will not be eligible to enroll upon acquisition of new Dependents.

LOSS OF HEALTH COVERAGE

You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience a loss of other coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was offered; and

- You and/or Your Dependents stated in writing that You declined coverage due to coverage under another group health plan or health insurance policy; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer

TERMINATION

- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or

- If Your Dependent Child qualifies for extended Dependent coverage because they are Totally Disabled, the day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or

- The day of the month in which the Dependent becomes covered as an Employee under this Plan; or

(There are two ways in which this 18-

COBRA NOTICE PROCEDURES

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing or via the online portal, if available, in order to continue group health coverage and must make the required payments when due in order to remain covered. If online election is available, You will receive instructions for online election when Your election notice is provided. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the re4(he)m612 792 reW*nBT/F2 -14(a2 TJETQ)-4(ovge)-7(wh)-8(on)4(t)-9(o a)4. ATely to the da8(i)5(c)-5(es)-3(

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Second Qualifying Events (Dependents Only): If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B, or both) or is divorced or legally separated, or if the Dependent Child loses eligibility under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. Dependents acquired during COBRA continuation (other than newborns and newly adopted Children) are not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will lead to the extension only when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or

EARLY TERMINATION OF COBRA CONTINUATION

- A reduction in work hours of the covered Employee.

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  Employee terminates coverage for their spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA[di)7(v)-5(oCi)-6(on)4( )-10(0.008.4912 0 612 792 reW*nBgl)7(e)-9(n3(l)-5(eg)4(p)-9(a

PROTECTION FROM BALANCE BILLING

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OUT-OF-NETWORK BENEFITS

When covered health care services are received from an Out-of-Network provider as described below, allowed amounts are determined as follows:

- For non-Emergency covered health care services received at certain network facilities from Out-of-Network Physicians when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary of Health and Human Services (including non-Ancillary Services that have satisfied the notice and consent criteria but unforeseen, urgent medical needs arise at the time the services are provided), the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

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

- For Emergency health care services provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your applicable Copay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For air Ambulance Transportation provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your Copay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

After the Plan has issued payment for covered health care services, the Plan may be required to pay the SURYLGHU DQ DGGLWLRQDO DPRXQW RU GLVFRXQW WR UHVROYH DQG V

PROVIDER NETWORK

The word **"Network"**

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, LPSURYH RU VWDELOL]H WKH &RYHUHG 3HUVRQ¶V FRQGLWLRQ RU LI D 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 International Classification of Diseases (ICD) or 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. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care benefits.

2. **Abortions:** ,I D 3K\VLFLDQ VWDWHV LQ ZULWLQJ WKDW WKH PRWKHU¶V C to be carried to term or if the pregnancy was the result of incest or rape.

3. **Allergy Treatment,** including injections and sublingual drops, testing and serum.

4. **Ambulance Transportation:**

   - Emergency Ambulance Transportation by a licensed ambulance service (ground or air) to an appropriate Hospital where the required Emergency health care services can be performed.
   - Non-Emergency 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. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport to the nearest facility able to provide appropriate medical care.

5. **Anesthetics and Their Administration.**

6. **Aquatic Therapy.** (See Therapy Services below.)

7. **Augmentation Communication Devices** and related instruction or therapy.

8. **Autism Spectrum Disorders (ASD) Treatment.**

   ASD treatment may include any of the followingTf1 0 0 1 99.024 169.1 Tm046 Tm0 g0 G[t)-8(he)4(s)-4(i)5(c)-5(kf0)5

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9. **Breast Pumps** and related supplies. Benefits for breast pumps include the lesser cost of purchasing or renting one breast pump per pregnancy in conjunction with childbirth.

10. **Breast Reductions** if Medically Necessary.

11. **Breastfeeding Support, Supplies, and Counseling** in conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period.

12. **Cardiac Pulmonary Rehabilitation** when Medically Necessary when needed as a result of an Illness or Injury.

13. **Cardiac Rehabilitation** programs are covered when Medically Necessary, if referred by a Physician, for patients who have certain cardiac conditions.

    Covered services include:

    - Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
    - Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital U H K D E L O L W D W L R Q I D F L O L W \ D Q G L Q F O X G H P R Q L W R U L Q J R I W K H & blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

14. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract 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.

15. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

16. **Cleft Palate and Cleft Lip,** benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

17. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.

    The following contraceptives will be processed under the medical Plan:

    - Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.
    - Contraceptive device 434.83 Tm0ETET-5(es)-3(()-2(fr)-2(amET0ET00300494604t[refr4604t8.33 TlNm-5(e)-8(E

25. **Extended Care Facility Services** for both mental and physical health diagnoses. Charges will be paid under the applicable diagnostic code. The following services are covered:

- x Room and board.
- x Miscellaneous services, supplies, and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

26. **Eye Refractions** if related to a covered medical condition.

27. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

- x Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
- x 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.
- x Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

28. **Gender Dysphoria:**

Benefits for the treatment of Gender Dysphoria include only the following treatments if those treatments are determined to be Medically Necessary and appropriate for an individual:

- x Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses
- x Cross-sex hormone therapy:
  - ¾ Cross-sex hormone therapy administered by a medical provider (for example, during an office visit)
  - ¾ Cross-sex hormone therapy dispensed from a pharmacy
- x Puberty-suppressing medication injected or implanted by a medical provider in a clinical setting
- x Laboratory testing to monitor the safety of continuous cross-sex hormone therapy
- x Surgery for the treatment of Gender Dysphoria, including the surgeries listed below:

  Male to Female:
  - ¾ Clitoroplasty (creation of clitoris)
  - ¾ Labiaplasty (creation of labia)
  - ¾ Orchiectomy (removal of testicles)
  - ¾ Penectomy (removal of penis)
  - ¾ Urethroplasty (reconstruction of female urethra)
  - ¾ Vaginoplasty (creation of vagina)

  Female to Male:
  - ¾ Bilateral mastectomy or breast reduction
  - ¾ Hysterectomy (removal of uterus)
  - ¾ Metoidioplasty (creation of penis, using clitoris)
  - ¾ Penile prosthesis
  - ¾ Phalloplasty (creation of penis)
  - ¾ Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
  - ¾ Scrotoplasty (creation of scrotum)
  - ¾ Testicular prosthesis
  - ¾ Urethroplasty (reconstruction of male urethra)
  - ¾ Vaginectomy (removal of vagina)
  - ¾ Vulvectomy (removal of vulva)

32. **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 may include:

- **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required 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,** which provides or arranges for other services related to the Terminal Illness, including 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 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.
- **Bereavement Counseling** V H U Y L F H V W K D W D U H U H F H L Y H G E \ D &R Y H U H G 3 H Z K H Q G L U H F W O \ F R Q Q H F W H G W R W K H &R Y H U H G 3 H U V R Q ¶ V G H D W K with other hospice charges. Counseling services must be provided by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within six months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. However, services 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.

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44. **Nutritional Counseling.**

45. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** that are prescribed by a Physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. 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 or are part of a chemotherapy regimen.

46. **Occupational Therapy.** (See Therapy Services below.)

47. **Oral Surgery** includes:

- 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.
- Frenectomy (the cutting of the tissue in the midline of the tongue).
- Excision of exostosis of jaws and hard palate.

48. **Orthognathic, Prognathic, and Maxillofacial Surgery** when Medically Necessary.

49. **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 custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.

50. **Oxygen and Its Administration.**

51. **Pharmacological Medical Case Management** (medication management and lab charges).

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

53. **Physician Services** for covered benefits.

54. **Pre-Admission Testing** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

55. **Prescription Medications** that 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 facili1 0 0 1 99.024 442a4 /METQq92 r//F1 9.96 TfnBT/F2 9.96 Tf0 G[-)]TJ Fica

59. **Qualifying Clinical Trials** as defined below, including routine patient care costs Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- x Cancer or other Life