CenturyLink Retiree and Inactive Health Plan

Highmark PPO Plan Option

(with Virtual PPO and Prescription Drugs)

SUMMARY PLAN DESCRIPTION

For Eligible

CenturyLink Retired and Inactive Former Bargaining Employees

(**Qwest Represented Only)**

CenturyLink, Inc.

Effective January 1, 2019

Updated October 2018

TABLE OF CONTENTS

INTRODUCTION

CenturyLink, Inc. (hereinafter "CenturyLink" or "Company") is pleased to provide you with this Summary Plan Description ("SPD"). This SPD presents an overview of the Benefits available under the Highmark (BlueCross BlueShield) Preferred Provider Organization ("PPO"), including prescription drugs, benefit option under the **CenturyLink Retiree and Inactive Health Plan (the "Plan")**.

This SPD must be read in conjunction with the *General Information SPD* which explains many details of your coverage and provides a listing of the other benefit options under the Plan.

The effective date of this updated SPD is January 1, 2019. If you are a Covered Person in the PPO Plan benefit option of the Plan on or after January 1, 2019, this SPD supersedes and replaces, in its entirety, any other previous printed or electronic SPD describing medical plan Benefits that you currently may possess. In the event of any discrepancy between this SPD and the official *Plan Document*, the *Plan Document* shall govern.

This SPD, together with other plan documents (such as the Summary of Material Modifications (SMMs), the *General Information SPD* and materials you receive at Annual Enrollment) (hereafter "Plan documents") briefly describe your Benefits as well as rights and responsibilities, under CenturyLink Retiree and Inactive Health Plan. These documents make up your official Summary Plan Description for the PPO Plan benefit option as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This PPO medical benefit option and the prescription drug Benefits under the Plan are self-funded; however, certain other benefit plan options under the Plan may be insured.

The Patient Protection and Affordable Care Act Known as the "Affordable Care Act"

As a standalone retiree health care plan, the CenturyLink Retiree and Inactive Health Care Plan is exempt from the requirements of the Patient Protection and Affordable Care Act ("PPACA" or "Affordable Care Act"). While CenturyLink has decided to voluntarily comply with certain provisions of PPACA, this voluntary compliance does not waive the Plan's exempt status. The Company may choose in its sole discretion to no longer apply these provisions at any time.

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan does provide minimum essential coverage. In addition, The Affordable Care Act establishes a minimum value standard of benefits to a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

This SPD is for eligible CenturyLink Retired and Inactive former Qwest Bargaining (Represented) Employees. *All other CenturyLink Employees and Retirees should refer to their own applicable CenturyLink Health Care Plan SPDs, with distinct terms and conditions.*

Company's Reserved Rights
CenturyLink reserves the right to amend or terminate any of the Benefits provided in the Plan – with respect to all classes of Covered Person, retired or otherwise – without prior notice to or consultation with any Covered Person, subject to applicable laws and if applicable, the collective bargaining agreement.

The Plan Administrator, the CenturyLink Employee Benefits Committee, and its delegate(s), has the right and discretion to determine all matters of fact or interpretation relative to the administration of the Plan and all benefit options—including questions of eligibility, interpretations of the Plan provisions and any other matter. The decisions of the Plan Administrator and any other person or group to whom such discretion has been delegated, including the Claims Administrator (Highmark), shall be conclusive and binding on all persons. More information about the Plan Administrator and the Claims Administrator (Highmark) can be found in the General Information SPD.

NOTE: While the Plan has processes in place to prevent errors and mistakes, if a clerical error or mistake happens (however occurring) such error or mistake does not create a right to a Benefit or benefit premiums under the Plan. You have an obligation to correct any errors or omissions that come to your attention by calling the Service Center to correct the error or omission immediately. *There are deadlines to file claims and benefit related actions; please refer to the section titled* **Time Deadline to File a Claim and the Time Deadline to File a Benefit-Related Lawsuit** in this SPDs and in *the General SPD for more information about the timing of these deadlines.*

The Required Forum for Legal Disputes
After the claims and appeals procedures are exhausted as explained above, and a final decision has been made by the Plan Administrator, if a Participant wishes to pursue other legal proceedings, the action must be brought in the United States District Court in Denver, Colorado.

How to Use This Document
The SPD is designed to provide you with a general description, in non-technical language of the Benefits currently provided under the PPO Plan benefit option without describing all of the details set forth in the *Plan Document*. The SPD is not the *Plan Document*. Other important details can be found in the *Plan Document* and the *General Information SPD*. The legal rights and obligations of any person having any interest in the Plan are determined solely by the provisions of the Plan. If any terms of the *Plan Document* are in conflict with the contents of the SPD, the *Plan Document* will always govern.

Capitalized terms are defined in the *Glossary* section and/or throughout this SPD and in the *General Information SPD*. All uses of "we," "us," and "our" in this document, are references to the Claims Administrator (Highmark) or CenturyLink. References to "you" and "your" are references to people who are Covered Persons as the term is defined in the *General Information SPD*.

You are encouraged to keep all of the SPDs and any attachments (summary of material modifications ("SMMs"), amendments, Summaries of Benefits Coverage, Annual Enrollment Guides and addendums) for future reference. Many of the sections of this SPD are related to other sections. You may not have all of the information you need by reading just one section.

Please note that your health care Provider does not have a copy of the SPD and is not responsible for knowing or communicating your Benefits.

See the *General Information SPD* for more information as noted in the *General Plan Information* section and throughout this document.

Exempt Retiree Medical Plan Status Notice

The CenturyLink Retiree and Inactive Health Plan (the "Plan") meets the requirements of a stand-alone exempt retiree medical plan under the Section 732 of ERISA and therefore is not required to comply with the Patient Protection and Affordable Care Act (PPACA). However, CenturyLink has decided to voluntarily apply certain provisions of the PPACA to certain benefit options. For example, CenturyLink is making coverage available to the end of the month in which your adult child(ren) attains the age of 26, provided such individual is not otherwise eligible for coverage under another group plan such as one offered by the child's employer. This means that for all Retirees, this voluntary application of PPACA may be changed or ended at any time and does not waive the Plan's status as "exempt" from PPACA.

Health Plan Coverage Is Not Health Care Advice

Please keep in mind that the sole purpose of the Plan is to provide for the payment of certain health care expenses and not to guide or direct the course of treatment of any Retiree or eligible Dependent. Just because your health care Provider recommends a course of treatment does not mean it is approved or payable under the Plan. A determination by the Claims Administrator (Highmark) or the Plan Administrator that a particular course of treatment is not eligible for payment or is not covered under the Plan does not mean that the recommended course of treatments, services or procedures should not be provided to the individual or that they should not be provided in the setting or facility proposed. ***Only you and your health care Provider can decide what is the right health care decision for you.*** *Decisions by the Claims Administrator (Highmark) or the Plan Administrator are solely decisions with respect to Plan coverage and do not constitute health care recommendations or advice.*

GENERAL PLAN INFORMATION

The PPO benefit option is just one benefit option offered under the Plan. Refer to the *General Information SPD* for important and general Plan information including, but not limited to, the following sections:

- Eligibility
- When Coverage Begins
- When Coverage Ends
- How to Appeal a Claim
- Circumstances that May Affect Your Plan Benefits
- The Plan's Right to Restitution
- Coordination of Benefits
- Plan Information (e.g. Plan Sponsor and EIN, administration, contact information, Plan Number, etc.)
- A statement of your ERISA Rights
- Notice of HIPAA Rights
- Your Rights to COBRA and Continuation Coverage
- Statement of Rights Under the Women's Health and Cancer Rights Act
- Statement of Rights Under the Newborns' and Mother's Health Protection Act
- General Administrative Provisions
- Required Notice and Disclosure
- Glossary of Defined Terms
- Qualified l Child Support Order (QMCSO)

You can go online at www.centurylink.com/healthandlife to obtain an electronic copy of the **General Information SPD** or call the CenturyLink Service Center at 800-729-7526 to request a paper copy.

You May Not Assign Your Benefits to Your Provider
Participants and Eligible Dependents may not voluntarily or involuntarily assign to a physician, hospital, pharmacy or other health care provider (your "Providers") any right you have (or may have) to:

(1) receive any benefit under this Plan,
(2) receive any reimbursement for amounts paid for services rendered by Providers, or
(3) request any payment for services rendered by Providers.

The Plan prohibits Participants and Eligible Dependents from voluntarily or involuntarily assigning to Providers any right you have (or may have) to submit a claim for benefits to the Plan, or to file a lawsuit against the Plan, the Company, the Plan Administrator, the Claims Administrator (Highmark), the appeals administrator or any other Plan fiduciary, administrator, or sponsor with respect to Plan benefits or any rights relating to or arising from participation in the Plan. If

Participants and Eligible Dependents attempt to assign any rights in violation of the Plan terms, such attempt will not be effective. It will be void or otherwise treated as invalid and unenforceable.

This Plan provision will not interfere with the Plan's right to make direct payments to a Provider. However, any direct payment to a Provider is provided as a courtesy to the Provider and does not effectuate an assignment of Participants' and Eligible Dependents' rights to the Provider or waive the Plan's rights to enforce the Plan's anti-assignment terms. Any such direct payment to a Provider shall be treated as though paid directly to Participants and Eligible Dependents and shall satisfy the Plan's obligations under the Plan.

Consequences of Falsification or Misrepresentation

You will be given advance written notice that coverage for you or your Dependent(s) will be terminated if you or your Dependent(s) are determined to falsify or intentionally omit information, submit false, altered, or duplicate billings for personal gain, allow another party not eligible for coverage to be covered under the Plan or obtain Plan Benefits, or allow improper use of your or your Dependent's coverage.

Continued coverage of an ineligible person is considered to be a misrepresentation of eligibility and falsification of, or omission to, update information to the Plan. This misrepresentation/omission is a violation of the Plan document, Section 8.3 which allows the Plan Administrator to determine how to remedy this situation. For example, if you divorce, your former spouse is no longer eligible for Plan coverage and this must be timely reported to the CenturyLink Service Center within 45 days, regardless if you have an obligation to provide health insurance coverage to your ex-spouse through a Court Order.

- You and your Dependent(s) will not be permitted to benefit under the Plan from your own misrepresentation. If a person is found to have falsified any document in support of a claim for Benefits or coverage under the Plan, the Plan Administrator may, without anyone's consent, terminate coverage, possibly retroactively, if permitted by law (called "rescission"), depending on the circumstances, and may seek reimbursement for Benefits that should not have been paid out. Additionally, the Claims Administrator (Highmark) may refuse to honor any claim under the Plan or to refund premiums.
- While a court may order that health coverage must be maintained for an ex-spouse/domestic partner, that is <u>not</u> the responsibility of the Company or the Plan.
- You are also advised that by participating in the Plan you agree that suspected incidents of this nature may be turned over to the Plan Administrator and or Corporate Security to investigate and to address the possible consequences of such actions under the Plan. All Covered Persons are periodically asked to submit proof of eligibility and to verify claims.

***Note**: All Participants by their participation in the Plan authorize validation investigations of their eligibility for Benefits and are required to cooperate with requests to validate eligibility by the Plan and its delegates.*

For other loss of coverage events, refer to the *General Information SPD* as applicable.

You Must Follow Plan Procedures

Please keep in mind that it is very important for you to follow the Plan's procedures, as summarized in this SPD, in order to obtain Plan Benefits and to help keep your personal health information private and protected. For example, contacting someone at the Company other than the Claims Administrator (Highmark) or Plan Administrator (or their duly authorized delegates) in order to try to get a Benefit claim issue resolved is not following the Plan's procedures. If you do **not** follow the Plan's procedures for claiming a Benefit or resolving an issue involving Plan Benefits, there is no guarantee that the Plan Benefits for which you may be eligible will be paid to you on a timely basis, or paid at all, and there can be no guarantee that your personal health information will remain private and protected.

Plan Number

The Plan Number for the CenturyLink Retiree and Inactive Health Plan is 511.

CLAIMS ADMINISTRATOR (HIGHMARK) AND CONTACT INFORMATION

The Claims Administrator's customer service staff is available to answer your questions about your coverage Monday through Friday: 8:00 AM – 8:00 PM (EST). Hours are subject to change without prior notice.

Highmark BlueCross BlueShield	Medical claims 888-778-8334 Blues On Call 888-BLUE-428 (258-3428)
Highmark Website	You are encouraged to visit **www.highmarkbcbs.com** to take advantage of several self-service features including: viewing your claim status and finding Network Physicians in your area.
Healthcare Management Services (HMS)	**Prior Authorization** is required **before** you receive certain Covered Health Services. Contact Healthcare Management Services at the toll-free Customer Service number shown on your medical ID card **before** receiving these services. References to *Prior Authorizations will be noted throughout* this SPD for additional information.

Mental Health/Substance Use Disorder	To obtain mental health/substance use disorder Prior Authorization or to contact a care manager (available seven days a week, 24 hours a day), contact Highmark Behavioral Health at 800-628-0816.
Claims Administrator's Mailing Address	**Medical Claims** To file medical claims, mail the claim form to: Highmark BCBS Attention: Claims P. O. Box 3355 Pittsburgh, PA 15230-0007 **Requests for Review of Denied Claims and Notice of Complaints:** **Medical Appeals/Complaints:** To file a medical appeal for Highmark, mail the appeal to: Highmark BCBS Attention: Appeals P.O. Box 3355 Pittsburgh, PA 15230-0007 **Mental Health/Substance Use Disorder Appeals/Complaints:** For Covered Persons who file a formal written complaint, their advocate will be the appeals coordinator in Member Relations who will thoroughly investigate the matter and bring it to resolution. Resolution on formal complaints is communicated in writing within 30 days. You may submit written complaints to: Highmark BCBS Attention: Claims P. O. Box 3355 Pittsburgh, PA 15230-0007 **Prescription Drug Appeals:** To file a Prescription Drug appeal, mail the appeal to: UnitedHealthcare Appeals

	P.O. Box 30432 Salt Lake City, UT 84130-0432 For more information on how to appeal a claim, refer to the *Claims Procedures* section.
Prescription Drug Program **OptumRx** **(including mail order refills)**	For information regarding Prescription Drugs call 800-842-1219 or **www.myuhc.com.** Refer to the *Prescription Drug Benefits* section later in this SPD for more information.

HIGHMARK PPO BENEFIT OPTION SERVICE AREA

Eligibility

If you are eligible for medical coverage under the Plan, (refer to the *General Information SPD* for more information regarding eligibility and other important information), you may have several choices of which medical benefit option to enroll in. To be eligible for the Highmark BlueCross BlueShield (BCBS) PPO benefit option, you must live inside of the established Highmark (BCBS) ***Blue Card PPO Network***. (The Claims Administrator (Highmark) has several Network choices in which Providers may participate. In most areas, the Claims Administrator (Highmark) contracts specifically for the ***Blue Card PPO Network*** for our Network Benefits.) When accessing the Claims Administrator's (Highmark) web site to locate Providers or when speaking with Providers, you should refer to the ***Blue Card PPO Network*** to make sure that you are accessing the correct Network Providers.

About the PPO Benefit Option

The PPO benefit option which covers hospitalization, surgery, inpatient and outpatient care, diagnostics, prescription drugs, home health care, and a variety of other medical services and supplies is administered by the Claims Administrator (Highmark). Mental Health and Substance Use Disorder Services are administered by Highmark.

The PPO benefit option also includes a number of medical cost and care management features such as Provider Networks, Blue Distinction Center and Blue Distinction Plus Center Networks for certain specialized care, Freestanding Facilities (clinics) and Prior Authorization programs. You typically experience lower out-of-pocket expenses by using Network Providers. By aggressively working to contain medical care costs while also maintaining quality service, the Company helps to keep high-quality medical care available for you and your Dependents.

The PPO benefit option pays a portion of your covered medical expenses, depending on the Network status of the care. Your share of the costs is determined by Copays, Deductibles, Coinsurance, and Out-of-Pocket Maximums.

The remainder of this SPD provides more details about the specific Benefits and provisions of the PPO benefit option.

Identification Card
The Blue Cross and Blue Shield symbols on your identification (ID) card are recognized throughout the country and around the world. Carry your ID card with you at all times, destroy any previously issued cards, and show this card to the hospital, doctor or other health care professional whenever you need medical care.

If your card is lost or stolen, please contact Highmark Member Service immediately. You can also request additional or replacement cards online by logging onto **www.highmarkbcbs.com**.

Below is a sample of the type of information that will be displayed on your ID card:

- Your name and your Dependent's name, if applicable
- Identification number
- Group number
- Copayment for physician office visits and emergency room visits
- Member Service toll-free number (on back of card)
- Precertification toll-free number (on back of card)
- "PPO in Suitcase" symbol

There is a logo of a suitcase with "PPO" inside it on your ID card. This PPO suitcase logo lets hospitals and doctors know that you are a member of a Blue Cross and Blue Shield PPO, and that you have access to PPO providers nationwide.

PPO PLAN FEATURES AND HOW THE PLAN WORKS

The PPO benefit option consists of Network, Out-of-Network, Virtual Network and "Gap Exception" provisions, depending on your geographic location of residence and how you utilize the Plan to access your Benefits as described below.

Network/Out-of-Network Benefits and Providers

Important
Highmark (BCBS) provides you with access to a large number of Network Providers. You will notice the website listed throughout the SPD, **www.highmarkbcbs.com**, which can be accessed by you to obtain Benefit information, ***locate Network Providers and Freestanding Facilities*** request ID Cards, and research health topics. Additional information on the website can be found in the *Resources to Help You Stay Healthy* section.

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choice to receive Network Benefits or Out-of-Network Benefits will affect the amounts you pay, as well as the level of Benefits you receive and any Benefit limitations that may apply. **Note: CenturyLink uses the *UHC Choice Plus* network of providers.**

You can receive even higher benefits by accessing certain *freestanding* network facilities (which is an outpatient, diagnostic or ambulatory center or independent laboratory which submits claims as a freestanding entity and not as a hospital). See below for more details about these added provisions.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with the Claims Administrator (Highmark) to provide those services.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or Out-of-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a Out-of-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Out-of-Network Benefits apply to Covered Health Services that are provided by a Out-of-Network Physician or other Out-of-Network provider, or Covered Health Services that are provided at a Out-of-Network facility.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a Out-of-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider. Depending on the geographic area and the service you receive, you may have access through UnitedHealthcare's Shared Savings Program to Out-of-Network providers who have agreed to discounts negotiated

from their charges on certain claims for Covered Health Services. Refer to *Glossary*, of this SPD for details about how the Shared Savings Program applies.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the Out-of-Network provider about their billed charges *before* you receive care.

Out-of-Network Benefits Exception (Gap Exception)
(not applicable to Retirees living in Virtual Network areas)
You may be eligible to receive Benefits for certain Out-of-Network Covered Health Services paid at the Network level if you do not have access to a Network provider within a certain mile radius of your home zip code depending on the state in which you reside. This is called a Gap Exception. **Highmark must approve any Benefits payable under this exception before you receive care.** If approved, your eligible claims will be paid at 80% of billed charges.

You can check a provider's Network status by visiting **www.highmarkbcbs.com** or by calling Highmark at the toll-free number on your ID card.

Virtual Network Benefits
If you live outside of the PPO Plan Network area ("out of area") the Plan will still pay Benefits for you and your enrolled covered dependents at Network levels. This "Virtual Network" is designed to help Retirees ***who live in rural areas with no access to Network providers***. You may be asked to pay the provider at the time of service and then submit a claim to the Plan for reimbursement.

After you have satisfied the required Network Deductible, Coinsurance and/or Copayments, the Plan will pay the same level of Benefits as the Network PPO Plan—you will be responsible for any remaining amount. Covered services will be subject to "Eligible Expenses" as described in the *Glossary* section. You will ***automatically*** be enrolled in the Virtual Network if this is applicable (otherwise this is not available to you) and your ID will also include an "out of area" designation.

Network and Out-of-Network Providers (for Virtual Network)
You have the freedom to choose the Physician, facility or health care professional you prefer each time you need to receive Covered Health Services. The choice you make to receive these Network Benefits or Out-of-Network Benefits affect the amounts you pay.

Generally, when you receive Covered Health Services from a Network provider (including facilities), you pay less than you would if you receive the same care from a Out-of-Network provider. However, since you may not have direct access to the

Network providers, your *level* of Benefits will be the same if you visit a Network provider or Out-of-Network provider. Because the total amount of Eligible Expenses may be less when you use a Network provider, the portion you pay will be less. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider. *(**Note**: You may find some types of Network providers (including Freestanding facilities) near you or you can travel further to seek care from a Network provider if you wish.)*

Network Providers. The Claims Administrator (Highmark) or its affiliates arrange for health care providers to participate in a Network. At your request, the Claims Administrator (Highmark) will send you a custom directory of Network providers (including lactation counseling providers) free of charge. Keep in mind, a provider's Network status is subject to change. To verify a provider's status or request a provider directory, you can call The Claims Administrator (Highmark) at the Customer Service phone number on the back of your ID card or log onto **www.highmarkbcbs.com**. You can also check directly with the Provider's office to see if they participate in the **Blue Card PPO** Network.

Freestanding Facilities
Freestanding Facilities are network facilities which are used for outpatient, diagnostic or ambulatory centers or standalone laboratories which perform services and submit claims as an independent entity and not as a hospital.

How to Find a Freestanding Facility:
- Log into **www.highmarkbcbs.com**
- Select "Find a Provider" to find doctors and facilities in your network by name, specialty, facility or condition.
- Choose a specialty and the facility will be indicted if it is a "Freestanding Facility".
- You can also call the customer service phone number on the back of your ID card for more details

You will have a lower co-insurance (15% instead of 20% after meeting your annual deductible) when you use a Freestanding network facility instead of a hospital for outpatient services.

Note: Network providers are independent practitioners and are not Employees of CenturyLink or the Claims Administrator Highmark).

Out-of-Network Provider. These Providers are not listed by Highmark BCBS on **www.highmarkbcbs.com**. It is best to confirm with the Provider's office before you receive services if they are in the Highmark **Blue Card PPO** Network or a Out-of-Network provider. Provider network status is subject to change.

Eligible Expenses
Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in the *Glossary* section. For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. The Plan has delegated to the Claims Administrator (Highmark) the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

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

For those residing in the PPO Network, there are separate Network and Out-of-Network Annual Deductibles for this Plan. Eligible Expenses charged by both Network and Out-of-Network providers apply towards both the Network individual and family Deductibles and the Out-of-Network individual and family Deductibles, accordingly.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

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

Coinsurance
Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible. Coinsurance amounts apply towards the Out-of-Pocket Maximums.

Coinsurance – Example
Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 80% after you meet the Annual Deductible, you are responsible for paying the other 20%. This 20% is your Coinsurance. This also applies if you access a where the Plan pays 85% after you meet the Annual Deductible, you are then responsible for paying the other 15% of your coinsurance.

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

There are separate Network and Out-of-Network Out-of-Pocket Maximums for this Plan. Eligible Expenses charged by both Network and Out-of-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the Out-of-Network individual and family Out-of-Pocket Maximums, accordingly.

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

For those residing in the PPO Network, the following table identifies what does and does not apply toward your Network and Out-of-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Out-of-Network Out-of-Pocket Maximum?
Copays	Yes	Yes
Payments you make for Services received toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not notifying Health Management Services	No	No
Charges that exceed Eligible Expenses	No	No

For those residing in the PPO Virtual Network*,* the following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	Apply to the Out-of-Pocket Maximum?
Copays	Yes
Payments you make for Services received toward the Annual Deductible	Yes
Coinsurance Payments	Yes
Charges for non-Covered Health Services	No
Charges that exceed Eligible Expenses	No
The amounts of any reductions in Benefits you incur by not notifying Health Management Services	No

See the Covered PPO Plan Benefits section for specific dollar amounts for these provisions.

HEALTHCARE MANAGEMENT SERVICES (HMS)

The Claims Administrator (Highmark) provides a program called Healthcare Management Services designed to encourage personalized, efficient care for you and your covered Dependents.

For your Benefits to be paid under your program, at either the Network or Out-of-Network level, services and supplies must be considered medically necessary and appropriate.

Healthcare Management Services (HMS), a division of Highmark Blue Cross Blue Shield, or its designated agent, is responsible for determining whether care is medically necessary and provided in the appropriate setting.

An HMS nurse will review your request for services to ensure it is appropriate for the treatment of your condition, illness, disease or injury, in accordance to standards of good medical practice, and the most appropriate supply or level of service that can safely be provided to you. When applied to hospitalization, this further means that you require acute care as an inpatient due to the nature of the services rendered for your condition and you cannot receive safe or adequate care as an outpatient.

Requirements for Notifying Health Management Services (Prior Authorization)

You are responsible for notifying HMS of your admission. However, some facility providers will notify HMS of the inpatient admission on your behalf. Be sure to

verify that your provider is notifying HMS. If not, you are responsible for contacting HMS.

You should call 7 to 10 days prior to your planned admission**. For emergency admissions, call HMS within 48 hours of the admission, or as soon as reasonable possible.** You can contact HMS via the toll-free Member Service telephone number located on the back of your ID card.

If you do not notify HMS of your admission to a facility provider, HMS may review your care after services are received to determine if it was medically necessary and appropriate. **If your admission is determined not to be medically necessary and appropriate, you will be solely responsible for all costs not covered by your program.**

The services requiring notification include:

- Inpatient facility admissions. (For emergency admissions, contact Highmark within 48 hours of the admission or on the first working day following a weekend or holiday to avoid paying a $150 penalty).
- Home Health Care services (including Private Duty Nursing)
- Hospice care
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services
- Durable Medical Equipment and Prosthetic Devices that will cost more than $1,000 to purchase or rent
- Maternity care that exceeds the delivery timeframe as described under *Covered Medical Services*.
- Transplant services
- Obesity Surgery (must use a Blue Distinction Center facility)
- Sleep Studies

The following procedures also require that you notify HMS prior to receiving services in order for HMS to determine if they are Covered Health Services:

- Blepharoplasty (surgery to correct aging of the eyelids)
- Breast reduction and reconstruction (except for after cancer surgery)
- Vein stripping, ligation and sclerotherapy (an injection of a chemical to treat varicose veins).

These services will not be covered when considered to be cosmetic procedures.

Cardiac Management Program. The National Imaging Associates (NIA) will perform prior authorization for outpatient non-emergent Nuclear Cardiology

(Myocardial Perfusion) and Stress Echocardiography codes. An NIA Cardiologist will review all requests for medical necessity to determine the appropriateness of the test.

Radiology Management Program. The Radiology Management Program is a consumer-driven solution that encourages members to learn about their health care and involves them directly in their care choices. When members call NIA, they will speak with an experienced professional who will ensure their request is handled quickly and accurately. NIA handles any follow-up that is needed with the health care provider to make everything as convenient as possible for the member. They will work on the member's behalf to utilize the most appropriate, efficient and least invasive testing option available.

Network physicians ordering selected outpatient non-emergency imaging scans for their Highmark patients may obtain prior approval on behalf of the member. Preauthorization is mandatory for certain non-emergency outpatient advanced imaging procedures such as selected MRI's, selected CAT scans, and all Pet scans. The program does not apply to outpatient imagining services ordered while patients are in the emergency room, inpatient imaging services or imaging services provided during observation stays.

For notification timeframes, and reductions in Benefits that apply if you do not notify Healthcare Management Services, see the *Additional Benefit Coverage Details* section.

Contacting Healthcare Management Services is easy.
Simply call the toll-free Customer Service number on your ID card.

Special Note Regarding Medicare
If you are enrolled in Medicare on a primary basis and Medicare pays Benefits before the Plan, you are not required to notify Healthcare Management Services before receiving Covered Health Services. Since Medicare pays Benefits first, the Plan will pay Benefits second as described in the *Coordination of Benefits (COB)* section.

Healthcare Management Services' Care Utilization Review Process
In order to assess whether care is provided in the appropriate setting, HMS administers a care utilization review program comprised of prospective, concurrent and/or retrospective reviews. In addition, HMS assists hospitals with discharge planning. These activities are conducted by an HMS nurse working with a physician advisor. Here is a brief description of these review procedures:

Prospective Review
Prospective review, also known as precertification or pre-service review, begins upon receipt of treatment information.

After receiving the request for care, HMS:

- Verifies your eligibility for coverage and availability of Benefits;
- Reviews diagnosis and plan of treatment;
- Assesses whether care is medically necessary and appropriate;
- Authorizes care and assigns an appropriate length of stay for inpatient admissions.

Concurrent Review

Concurrent review may occur during the course of ongoing treatment and is used to assess the medical necessity and appropriateness of the length of stay and level of care.

Discharge Planning

Discharge planning is a process that begins prior to your scheduled hospital admission. Working with you, your family, your attending physician(s) and hospital staff, HMS will help plan for and coordinate your discharge to assure that you receive safe and uninterrupted care when needed at the time of discharge.

Retrospective Review

Retrospective review may occur when a service or procedure has been rendered without the required precertification.

Case Management Services

Should you experience a serious injury or illness, or need assistance in coordinating your care needs, the Case Management program may be able to provide assistance.

If accepted into the program, and with your permission, the program will:

- Work collaboratively with you, your family or significant others, and all your providers to coordinate and implement a plan of care which meets your holistic needs;
- Help identify community-based support and educational services to assist with your ongoing health care needs; and
- Assist in the coordination of Benefits and alternative resources.

Blues On Call^{sm} - 24/7 Health Decision Support

Just call **888-BLUE-428 (888-258-3428)** to be connected to a specially-trained wellness professional. You can talk to a Health Coach whenever you like, any time of the day, any day of the week.

Health Coaches are specially-trained registered nurses, dietitians and respiratory therapists who can help you make more informed health care and self-care (when appropriate) decisions. They can assist with a health symptom assessment, provide health-related information, and discuss your treatment options. Please be assured that your discussions with your Health Coach are kept strictly confidential.

Help with common illnesses, injuries and questions
Health Coaches can address any health topic that concerns you:

- Everyday conditions, such as a rash, an earache or a sprain
- A recent diagnosis you've received
- A scheduled medical test
- Planned surgery or other medical procedure
- Questions to ask your doctor at your next appointment
- How to care for a Child or elder

You don't have to be ill to talk to a Health Coach. Call to learn about programs and other resources available to help you manage:

- Stress
- Personal nutrition
- Weight management
- Physical activities
- Insomnia
- Depression

Help with chronic conditions
If you have diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease or coronary artery disease, you need to manage your condition every day in order to stay healthy and avoid hospital stays. That means keeping track of medications, tests, doctor appointments and your diet. Your Blues On Call Health Coach can help you work more closely with your doctor and get more involved in taking good care of yourself.
You can even establish a relationship with a specific Health Coach and schedule time to talk about your concerns and conditions.

myCare Navigator^{sm} - 24/7 Health Advocate Support
Getting the right care and finding the right doctor and wellness services for you and your family is now as quick and easy as calling myCare Navigator at **888-BLUE-428**.

Your dedicated health advocate can help you and your family members:

- locate a primary care physician or get an appointment with a hard-to-reach specialist;
- get your medical records transferred;
- get a second opinion;
- understand your health care options;
- locate wellness resources, such as services for your special needs Child or quality elder care for a parent; or
- handle billing questions and make the most of your care dollars.

Get the help you need to navigate the health care system easily and effectively. The same number that connects you to Blues On Call now connects you to your health advocate, myCare Navigator. Call **888-BLUE-428** for total care support!

COVERED PPO PLAN BENEFITS

Plan Highlights (PPO and Virtual Networks)
The table below provides a high-level overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	PPO Network (And "Virtual Network")	PPO Out-of-Network
Copays[1]		
• Physician's Office Services – Primary Physician	$25	Not Applicable
• Physician's Office Services - Specialist	$40	Not Applicable
• Urgent Care Center Services	$35	Not Applicable
Annual Deductible[2]		
• Individual	$500	$1,500
• Family (not to exceed $500 per Covered Person for a Network Provider and $1,500 per Covered Person for a Out-of-Network Provider)	$1,000	$3,000
Annual Out-of-Pocket Maximum[2]		
• Individual	$3,900	$5,700
• Family (not to exceed $3,900 per Covered Person for Network Provider and $5,700 per Covered Person for a Out-of-Network Provider)	$7,800	$11,500
Lifetime Maximum Benefit[3]	Unlimited	

Plan Features	PPO Network (And "Virtual Network")	PPO Out-of-Network

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

[2]Copays do not apply toward the Annual Deductible. However, the Copays and Annual Deductible apply toward the Out-of-Pocket Maximum for all Covered Health Services.

[3]There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan. Generally, the following are considered to be essential Benefits under the Patient Protection and Affordable Care Act:

> Ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Covered Benefits Summary Table

This table provides an **overview** of the Plan's coverage levels and is not intended to be a complete listing. For additional detailed descriptions of your Benefits, refer to the *Additional Coverage Details* section after this Table.

Note: *When accessing certain Freestanding Facilities, the Plan pays 85% rather than the 80%* ***where available.***

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
Abortion See the *Additional Benefit Coverage Details* section for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Acupuncture Services Up to 20 visits per calendar year (combined INN and OON)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Ambulance Services - Emergency Only (Ground & Air) ***Requires Prior Authorization if non-emergency*** See the *Additional Benefit Coverage Details* section for limits.	100%	100%
Chiropractic Care *See Spinal Treatment Benefit*		
Congenital Heart Disease (CHD) Surgeries ▪ Hospital - Inpatient Stay ***Requires Prior Authorization***	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
Dental Services - Accident Only	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Diabetes Services ▪ Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care ▪ Diabetes Self-Management Items	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible
Dialysis ***Requires Prior Authorization*** See the *Additional Benefit Coverage Details* section for limits.	**80% after you meet the Annual Deductible**	Not Covered
Durable Medical Equipment (DME) ***Requires Prior Authorization for some items*** See the *Additional Benefit Coverage Details* section for limits.	80% after you meet the Annual Deductible; or 100% for services received in office setting. Copay applies only	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
	with a physician office visit	
Emergency Health Services – Outpatient After three visits to the ER within the plan year, you will receive a call from a Well Connected nurse to remind you and assist you to consider other options of care for any future ER visits.	80% after you meet the Network Annual Deductible;	80% after you meet the Network Annual Deductible;
Enteral Nutrition (Formula) See the *Additional Benefit Coverage Details* section for limits.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Gender Identify Dysphoria See the *Additional Benefit Coverage Details* section for limits. ***Requires Prior Authorization***	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hearing Care Hearing Aids are covered up to $1,000 every three years per hearing		80% after you meet the

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
impaired ear (combined Network and Out-of-Network) (includes Surgery for cochlear implants)	80% after you meet the Annual Deductible	Annual Deductible
Home Health Care Up to 120 visits per calendar year (combined INN and OON) ***Requires Prior Authorization***	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospice Care ***Requires Prior Authorization***	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Hospital - Inpatient Stay ***Requires Prior Authorization***	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Infertility Services • Physician's Office Services (Copay is per visit; Physician office Copay only applies with office visit)	100% after you pay a $25 Copay /$40 Copay for Specialist with office visit	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
• Outpatient services received at a Hospital or Alternate Facility Benefits for infertility services are limited to $1,000 per Covered Person per calendar year up to $3,000 per Covered Person during the entire period you are covered under the Plan. *(**Note**: These Benefits do not apply to surrogacy services. See the Exclusions section for more details.)*	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Injections in a Physician's Office (Physician office Copay only applies with office visit). *See Preventive Care Services section for more information.*	100% after you pay a $25 Copay with office visit	60% after you meet the Annual Deductible
Lab, X-Ray and Diagnostics – Outpatient ***Requires Prior Authorization if related to Sleep Studies***	80% after you meet the Annual Deductible	80% after you meet the Network Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
Lab, X-Ray and Major Diagnostics (such as CT, PET, MRI, MRA, Nuclear Medicine, cardiology tests, etc.) – Outpatient ***Requires Prior Authorization*** *See Physician Services if services provided in physicians office*	80% after you meet the Annual Deductible	80% after you meet the Network Annual Deductible
Mental Health Services • Hospital - Inpatient Stay ***Requires Prior Authorization***	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
• Physician's Office Services (Copay is per visit; Physician office Copay only applies with office visit)	100% after you pay a $25 Copay with office visit	60% after you meet the Annual Deductible
Naturopathic Professional Services Up to 20 visits per Covered Person per calendar year for Network and Out-of-Network Benefits combined	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders • Hospital - Inpatient Stay ***Requires Prior Authorization***	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
• Physician's Office Services (Copay is per visit) (Physician office Copay only applies with office visit)	100% after you pay a $25 Copay with office visit	60% after you meet the Annual Deductible
Nutritional Counseling	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Obesity Surgery (Only covered if done at Blue Distinction Centers) • Physician's Office Services	80% after you meet the Annual Deductible	Not Covered
• Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	Not Covered

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
• Hospital - Inpatient Stay • Lab and x-ray See the *Additional Benefit Coverage Details* section for limits.	80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	Not Covered Not Covered
Orthotics Up to $350 per Covered Person per calendar year for foot orthotics for Network and Out-of-Network combined.	80% after you meet the Annual Deductible (even if combined with an office visit)	60% after you meet the Annual Deductible
Ostomy Supplies	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services Covered Health Services provided by a Out-of-Network consulting Physician, assistant surgeon or a	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
surgical assistant in a Network facility will be paid as Out-of-Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.		
Physician's Office Services - Sickness and Injury		
• Primary Physician (Copay is per visit) (Physician office Copay only applies with office visit)	100% after you pay a $25 Copay with office visit	60% after you meet the Annual Deductible
• Specialist Physician (Copay is per visit) (Physician office Copay only applies with office visit)	100% after you pay a $40 Copay for Specialist with office visit	60% after you meet the Annual Deductible
• Non-routine hearing aid exam (limited to $100 per calendar year)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
• Lab, X-Ray and Diagnostics *if* performed *in the physician's office* (excluding Major Diagnostics such as CT, PET,	100% after you pay the office copay	60% after you pay the office copay

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
MRI, MRA, Nuclear Medicine, cardiology tests, etc.)		
Pregnancy – Maternity Services • Physician's Office Services (Copay is per visit; Physician office Copay only applies with office visit. Prenatal services are covered at No Charge after the initial visit.) • Hospital - Inpatient Stay • Physician Fees for Surgical and Medical Services A Deductible will not apply for a newborn Child whose length of stay in the Hospital is the same as the mother's length of stay. **NOTE: Dependent Children (of any age) are not covered for <u>any</u> maternity benefits including complications resulting from pregnancy.**	100% after you pay a $25 Copay/ $40 Copay for Specialist with office visit 80% after you meet the Annual Deductible 80% after you meet the Annual Deductible	60% after you meet the Annual Deductible 60% after you meet the Annual Deductible 60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
See the Additional Benefit Coverage Details section for more details.		
Preventive Care Services • Physician Office Services	100%	Not Covered
• Lab, X-ray or Other Preventive Tests (includes MRI's performed for women who cannot have mammograms due to a mastectomy) (first screening each calendar year is considered as preventive)	100%	Not Covered
• Breast Pumps	100%	Not Covered
• Immunizations (*Injections* include the Shingles injections/shot received by a Network Provider and by a Network Pharmacy. *However, immunizations for personal travel are not covered.*)	100%	Not Covered
• Lactation counselors	100%	100%
• BRCA testing See the *Additional Benefit Coverage Details* section for more information.	100%	100%

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
Private Duty Nursing - Outpatient	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Reconstructive Procedures • Physician's Office Services (Copay is per visit; Physician office Copay only applies with office visit)	100% after you pay a $25 Copay /$40 Copay for Specialist with office visit	60% after you meet the Annual Deductible
• Hospital - Inpatient Stay ***Requires Prior Authorization***	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
• Physician Fees for Surgical and Medical Services	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
• Prosthetic Devices	80% after you meet the Annual Deductible	60% after you meet the

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
• Surgery – Outpatient ***Requires Prior Authorization***	80% after you meet the Annual Deductible; OR 100% after you pay a $25 Copay /$40 Copay for Specialist when received in a Physician office setting with office visit	Annual Deductible 60% after you meet the Annual Deductible
Rehabilitation Services - Outpatient Therapy	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Second Surgical Opinion See the *Additional Benefit Coverage Details* section for more limits.	100%	100%

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services ***Requires Prior Authorization*** Up to 120 days per calendar year per Covered Person per calendar year for Network and Out-of-Network Benefits combined	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Spinal Treatment Up to 20 visits per calendar year (combined In and Out of Network) See the *Additional Benefit Coverage Details* section	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Substance Use Disorder Services • Hospital - Inpatient Stay	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
• Physician's Office Services (Copay is per visit; Physician office Copay only applies with office visit)	100% after you pay a $25 Copay with office visit	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
Surgery - Outpatient ***Requires Prior Authorization for certain services***	80% after you meet the Annual Deductible; OR 100% after you pay a $25 Copay /$40 Copay for Specialist when received in a Physician office setting with office visit	60% after you meet the Annual Deductible
Temporomandibular Joint Dysfunction (TMJ)	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Therapeutic Treatments – Outpatient ***Requires Prior Authorization for certain services***	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible
Transplantation Services ***Requires Prior Authorization*** *See the Additional Benefit Coverage Details* section.	80% after you meet the Annual Deductible Certain services are covered at 100% if performed at **Blue**	60% after you meet the Annual Deductible

Covered Health Services[1]	Percentage of "Eligible Expenses" Payable by the Plan:	
	PPO (and Virtual Network*) (*subject to Eligible Expenses—see the *Glossary*)	**Out-of-Network* (not applicable to Virtual Network)** (*subject to Eligible Expenses—see the *Glossary*)
	Distinction Plus centers.	
Travel and Lodging (If services rendered by a Blue Distinction Center for Obesity services) See the *Additional Benefit Coverage Details* section for more information.	For patient and companion(s) of patient undergoing obesity surgery services or transplant procedures	
Urgent Care Center Services (Copay is per visit)	100% after you pay a $35 Copay	60% after you meet the Annual Deductible
Wigs Up to one wig after the chemotherapy treatment.	80% after you meet the Annual Deductible	60% after you meet the Annual Deductible

[1]**You must obtain Prior Authorization through Healthcare Management Services**, as described in the *Healthcare Management Services* section to receive full Benefits **before** receiving certain Covered Health Services from a Out-of-Network provider. In general, if you visit a Network provider, that provider is responsible for contacting Healthcare Management Services **before** you receive certain Covered Health Services. See the *Additional Benefit Coverage Details* section for further information.

Multiple Surgical Procedure Reduction Policy
When you have multiple procedures performed at the same time, the Plan will pay:

- 100% of your coinsurance amount for the primary or major surgical procedure;
- 50% of your coinsurance amount for the secondary procedure; and third procedure

Special rules for multiple endoscopic procedures may apply if multiple procedures are performed using the same scope. Secondary and subsequent procedures using the same scope are reduced based on a different percentage determined by the value of doing the diagnostic scope with no surgery.

Legal Action Deadline. There are claims and appeals and legal remedy deadlines as stated near the beginning of this SPD under the *General Plan Information* section.

ADDITIONAL BENEFIT COVERAGE DETAILS

This section supplements the *Covered Benefit Summary Table* above for the PPO Benefit Plan.

While the above table provides you with Benefit limitations along with Copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits and associated specialty Programs. These descriptions also include any additional limitations that may apply, as well as Covered Health Services for which **you must call Healthcare Management Services to obtain Prior Authorization**.

The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are <u>not</u> covered are described in the *Exclusions* section which is subject to change from time to time and over time.

Abortion
Benefits are only available if the life of the mother would be endangered by medical complications arising from the pregnancy, or in case of incest or rape. *Dependent Children are not covered under this Benefit, except in case of incest or rape.*

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

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

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

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

Benefits are limited to 20 treatments per calendar year. These visit limits apply to Network Benefits and Out-of-Network Benefits combined.

Ambulance Services - Emergency Only
The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital that offers Emergency Health Services. See the *Glossary* section for the definition of "Emergency".

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

Coverage includes non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance as UnitedHealthcare determines to be appropriate) between facilities when the transport is any of the following:

1) From a Out-of-Network Hospital to a Network Hospital;

2) To the closest Network Hospital or facility that provides Covered Health Services that were not available at the original Hospital or facility;

3) From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility.

Prior Authorization is required for non-emergency Ambulance service.

Clinical Trials

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

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

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

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

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the 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. The only exceptions to this are:
  - certain *Category B* devices;
  - certain promising interventions for patients with terminal illnesses; and
  - other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and

- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

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

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

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

    - ♦ comparable to the system of peer review of studies and investigations used by the *National Institutes of Health; and*
    - ♦ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
- the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
- the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial; or

- the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Prior Authorization is required for Clinical Trials.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Healthcare Management **Services as soon as the possible (ASAP)** of participation in a clinical trial arises. **If Prior Authorization Healthcare Management Services is not obtained ASAP, you will be responsible for paying all charges and no Benefits will be paid.** ***Call the phone number on the back of your ID card.***

Dental Services - Accident Only
Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident.

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

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

The Plan also covers Dental sedation and general anesthesia when determined by Physician to be medically necessary.

Before the Plan will cover treatment of an injured tooth, the dentist must certify that the tooth is virgin or unrestored, and that it:

- has no decay;
- has no filling on more than two surfaces;
- has no gum disease associated with bone loss;
- has no root canal therapy;
- is not a dental implant; and
- functions normally in chewing and speech.

Dental services for final treatment to repair the damage caused by accidental injury must be started within three months of the accident, or if not a covered participant at the time of the accident, within the first three months of coverage under the Plan, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident, or if not a covered participant at the time of the accident, within the first 12 months of coverage under the Plan.

Please remember that **you should notify** Healthcare Management Services as **soon as possible (ASAP)**, but **at least five business days BEFORE** follow-up (post-Emergency) treatment begins. You do not have to obtain Prior Authorization before the initial Emergency treatment. When **you request Prior Authorization in advance**, Healthcare Management Services can determine whether the service is a Covered Health Service. ***Call the phone number on the back of your ID card.***

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

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.
Diabetic Self-Management Items	Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. Children under the age of 18 can elect a pump that best fits their lifestyle and needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment* in this section, unless ordered by prescriber. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet

Covered Diabetes Services	
	devices are described in the *Prescription Drugs* Section. Benefits for diabetes self-management items will be the same as those stated under Durable Medical Equipment with the exception of insulin pumps, if ordered by prescriber. Children under the age of 18 can elect a pump that best fits their lifestyle and needs.

Prior Authorization is required for Diabetic items in excess of $1,000.

Dialysis – Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including but not limited to dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

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

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

Benefits under this section include:

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

- Please remember for Out-of-Network Benefits, you must notify Personal Health Support five business days before scheduled dialysis services are received or, for non-scheduled services, within one business day or as soon as reasonably possible. If Personal Health Support is not notified, Benefits will be subject to a $150 reduction.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Healthcare Management Services **BEFORE** obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item will **exceed $1,000**. You must purchase or rent the DME from the vendor Healthcare Management Services identifies. **If Prior Authorization is not obtained in advance, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

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

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable, with the exception of insulin pumps, if ordered by prescriber;
- supplies, including those that are disposable, for members under the age of 18 when there is a clinical need and is ordered by a prescriber;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

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

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps, blood glucose monitors and all related necessary supplies as described under *Diabetes Services* in this section, with the exception of insulin pumps, if ordered by prescriber;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

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

The Plan also covers foot orthotics up to $350 per calendar year. This dollar limit applies to Network Benefits and Out-of-Network Benefits combined. This Benefit is paid at 80% after you meet the Annual Deductible, ***even if provided in a physician's office***.

The Plan will allow coverage for DME supplies including those that are disposable, for members under the age of 18 when there is a clinical need and is ordered by a prescriber.

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

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

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan. Speech aid and trachea-esophageal voice devices and included in the annual limits stated above.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three calendar years.

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

Prior Authorization is required for Durable Medical Equipment and Prosthetic Devices items costing more than $1,000.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Healthcare Management Services if the retail purchase cost or cumulative rental cost of a single item will **exceed $1,000. To receive Network Benefits**, you must purchase or rent the DME from the vendor Healthcare Management Services identifies or purchase it directly from the prescribing Network physician. **If Prior Authorization is not obtained as stated above, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

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

After three visits to the ER within the plan year, you will receive a call from a Well Connected nurse to remind and assist you to consider other options of care for any future ER visits. These options include virtual visits, urgent care, convenience clinics or a call to NurseLine.

If you are admitted to a Hospital as a result of an Emergency directly from the Emergency room, the Benefits for an Inpatient Stay in a Network Hospital will apply. You must notify Healthcare Management Services within 48 hours or the same day of admission if possible.

Network Benefits will be paid for an Emergency admission to a Out-of-Network **Hospital as long as Healthcare Management Services is notified within one business day of the admission** or on the same day of admission if reasonably possible after you are admitted to a Out-of-Network Hospital. If you continue your stay in a Out-of-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Out-of-Network Benefits will apply.

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

When Covered Health Services are received from a Out-of-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are an amount negotiated by UnitedHealthcare or an amount permitted by law. Please contact UnitedHealthcare if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Healthcare Management Services ***within one business day*** of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. **If Prior Authorization is not obtained within one business day, Benefits for the Inpatient Hospital Stay will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Enteral Nutrition (Formula)
The Plan pays Benefits for Enteral nutrition if it is the sole source of nutrition and is specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU).

Foods that are <u>not</u> covered include:

- enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU).
- Infant formula available over the counter is always excluded.

Gender Identity Dysphoria
This benefit is for the treatment of Gender Dysphoria limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnosis.
- Cross-sex hormone Therapy:
    - Cross-sex hormone therapy administered by a medical provider
    - Cross-sex hormone therapy dispensed from a pharmacy
- Puberty suppressing medication injected or implanted by a medical provider in a clinical setting.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:
    - Male to Female
        - Clitoroplasty (creation of clitoris)
        - Colovaginalplasty
        - Labiaplasty (creation of labia)
        - Orchiectomy (removal of testicles)
        - Penectomy (removal of penis)
        - Urethroplasty (reconstruction of female urethra)
        - Vaginoplasty (creation of vagina)
    - Female to Male
        - Bilateral mastectomy or breast reduction

- Colpectomy
- Hysterectomy (removal or uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis implantation
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements are as follows:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the covered person meets all of the following criteria:
    - Persistent, well-documented Gender Dysphoria.
    - Capacity to make a fully informed decision and to consent for treatment.
    - Must be 18 years or older.
    - If significant medical or mental health concerns are present, they must be reasonably well controlled.

You must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the participant. The assessment must document that the participant meets all the following criteria.
    - Persistent, well-documented Gender Dysphoria.
    - Capacity to make a fully informed decision and to consent for treatment.
    - Must be 18 years or older.
    - If significant medical or mental health concerns are present, they must be reasonably well controlled.
    - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
    - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

See the *Medical Glossary* for more information on Gender Dysphoria.

Hearing Care
The Plan pays Benefits for routine hearing exams when services are received from a Provider in the Providers office.

Benefits for Hearing exams that are for Injury or Sickness are described in this section under *Physician's Office Services*.

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

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

Bone anchored hearing aids are a Covered Health benefit if they meet the following criteria:

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

Any combination of Network and Out-of-Network Benefits is limited to a $1,000 maximum per covered Person. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 calendar years.

Benefits for hearing exams in case of Injury or Sickness are limited to $100 per calendar year.

External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure.

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

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

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

Any combination of Network Benefits and Out-of-Network Benefits is **limited to 120 visits** per covered Person per calendar year. One visit equals four hours of Skilled Care services.

Prior Authorization is required for Home Health Care services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Healthcare Management Services **five business days BEFORE** receiving services or as soon as reasonably possible. **If Prior Authorization from is not obtained in advance, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

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

Prior Authorization is required for Hospice Care services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Healthcare Management Services ***five business days*** **BEFORE** receiving services. **If Prior Authorization from Healthcare Management Services is not obtained in advance, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Hospital - Inpatient Stay
Hospital Benefits are available for:

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

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

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

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

Prior Authorization is required for Hospital Inpatient services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Healthcare Management Services as follows:
■ for elective admissions: ***five business days*** **BEFORE** admission or **as soon as reasonably possible**;

■ for Emergency admissions (also termed non-elective admissions): **as soon as is reasonably possible**.

If Prior Authorization is not obtained as stated above, Benefits will be subject to a $150 reduction. ***Call the phone number on the back of your ID card.***

Infertility Services
The Plan pays Benefits for infertility services and associated expenses including:

- diagnosis and treatment of an underlying medical condition that causes infertility, when under the direction of a Physician;
- Assisted Reproductive Technologies (ART), including but not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT);
- Impregnation or fertilization charges are not covered for surrogate donor; actual or attempted;
- embryo transport;
- donor ovum and semen and related costs, including collection, preparation and storage of; and
- insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI)).

***(Note:** These Benefits do not apply to surrogacy services. See the Exclusions section for more details.)*

Any combination of Network Benefits and Out-of-Network Benefits for infertility services is **limited to a $1,000** maximum per Covered Person per calendar year **up to a $3,000** maximum per Covered Person per lifetime.

Only charges for the following apply toward the infertility lifetime maximum:

- Hospital outpatient facility;
- surgeon's and assistant surgeon's fees; anesthesia;
- lab and x-ray;
- diagnostic services;
- Physician's office visits;
- Consultations; and
- injections.

The cost of any prescription medication treatment for in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures and zygote intrafallopian transfer (ZIFT) procedures does count toward the infertility calendar year and lifetime maximum.

Please remember for Out-of-Network Benefits **you must obtain Prior Authorization** from Healthcare Management Services **as soon as the possibility (ASAP)** of the need for infertility services arises. **If obtain Prior Authorization** from **is not obtained ASAP, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Injections in a Physician's Office
Benefits are paid by the Plan for injections administered in the Physician's office, for example allergy immunotherapy, when no other health service is received. However, immunizations for personal travel are not covered.

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

- lab and radiology/x-ray; and
- mammography; and
- genetic counseling and genetic testing when ordered by the Physician and authorized in advance by the Claims Administrator (Highmark).

Benefits under this section include:

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

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, JRI, MRA, nuclear medicine and major diagnostic services are

described under *Lab, X-Ray and Major Diagnostics (such as CT, PET Scans, MRI, MRA, Nuclear Medicine, cardiology tests, etc.) -Outpatient* in this section.

Note**: These services are covered at 100% **only if performed in a physician's office.

Prior Authorization is required specifically for Sleep Studies—Outpatient.

Lab, X-Ray and Major Diagnostics (such as CT, PET Scans, MRI, MRA, Nuclear Medicine, cardiology tests, etc.) - Outpatient
Advanced Imaging services for CT scans, PET scans, MRI, MRA, nuclear medicine cardiology tests, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility **will require Prior Authorization. Failure to obtain Prior Authorization may result in no coverage**.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.
- Cardiology Services include:
- Outpatient diagnostic catheterizations
- Inpatient and outpatient electrophysiology implants
- Outpatient echocardiograms and stress echocardiograms

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

Note: *These services are covered at 80% after deductible, **even if performed in a physician's office.***

Prior Authorization is required for all these services.

Please remember for Out-of-Network Benefits**, you must obtain Prior Authorization** from Well Connected. **If Prior Authorization from Well Connected is not obtained in advance, Benefits will be subject to a $150 reduction. *Call the phone number on the back of your ID card.***

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

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

- diagnostic evaluations and assessment;

- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

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

Prior Authorization is required for Mental Health inpatient services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from the MH/SUD Administrator to receive these Benefits in **ADVANCE** of any treatment. Please refer to the *Healthcare Management Services* section for the specific services that require notification. **Without Prior Authorization, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Naturopathic Professional Services
The Plan covers Benefits for naturopathic professional services. Materials such as herbs and nutritional supplements are generally not covered by the Plan.

Benefits are limited to 20 visits per Covered Person per calendar year for Network and Out-of-Network Benefits combined.

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders
The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

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

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services; and
- crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

Prior Authorization is required for Neurobiological Disorder services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from the MH/SUD Administrator in **ADVANCE** to receive these Benefits. Please refer to the *Healthcare Management Services* section for the specific services that require notification. **Without Prior Authorization, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

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

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

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

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

Obesity Surgery
The Plan covers surgical treatment of (morbid) obesity provided by or under the direction of a Physician provided either of the following are true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 to 40 with co-morbid conditions; ***and***

- you have documentation from a Physician of a diagnosis of morbid obesity for a minimum of five years; **and**
- you are over the age of 18.

In addition to meeting the above criteria, all the following must also be true:

- you have completed a 6-month Physician supervised weight loss program;

- you have completed a pre-surgical psychological evaluation; and
- the surgery is performed at a **Blue Distinction Center (BDC)** even if there are no BDC Facilities near you.

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in the *Glossary* section and are not Experimental or Investigational or Unproven Services.

Benefits are **limited to one surgery** per lifetime unless there are complications to the covered surgery.

Orthotics
The Plan covers Benefits for orthotics when prescribed by a Physician. These Benefits are limited to:

- shoe orthotics
- arch supports
- orthotic braces that stabilize and injured body part; and
- braces to treat curvature of spine.

Any combination of Network Benefits and Out-of-Network Benefits is limited to a $350 maximum per Covered Person per calendar year for foot orthotics. This Benefit is paid at 80% In-Network after you meet the Annual Deductible, ***even if provided in a physician's office.***

Ostomy Supplies
Benefits for ostomy supplies are limited to:

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

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

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by Highmark), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility. Benefits include growth hormone therapy for Dwarfism secondary to pituitary gland failure.

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

The Plan covers Benefits for artificial disc replacement surgery which includes lumbar and cervical (Levels 1 and 2). **Healthcare Management Services notification is required.** ***Call the phone number on the back of your ID card.***

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

Pregnancy - Maternity Services
Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. **However, direct or indirect expenses incurred for a Dependent Child's pregnancy are <u>not</u> covered.** *This includes all maternity-related medical services including prenatal care, postnatal care, delivery, and any related complications.*

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

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

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

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

<u>Please note</u>: *A Retiree may not enroll an individual including a newborn as an Eligible Dependent unless in accordance with applicable time deadlines, such Eligible Dependent is or was declared to the Plan Administrator as eligible for coverage. To the extent at the time such Eligible Dependent is /was declared to as eligible for coverage but the Retiree at that time elects to suspend coverage in*

accordance with the Plan Administrator's procedures, the Retiree may later enroll such declared individual as an Eligible Dependent.

Benefits for Dependent Children. (***Note:*** *See information above. This Benefit may vary if you reside in Massachusetts. Please check with your specific carrier for more information.)*

Prior Authorization is required for maternity care that exceeds the above specified delivery timeframes.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from Healthcare Management Services **as soon as reasonably possible (ASAP)** if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. **If Prior Authorization from Healthcare Management Services is not obtained ASAP, Benefits for the extended stay will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Preventive Care Services

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

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, Children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. ***Note:*** *3D mammograms or digital breast tomosynthesis are covered as preventive only if submitted with a diagnosis of family history or breast cancer.*

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card. You can also refer to:

http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump.

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

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

Private Duty Nursing - Outpatient
The Plan covers Private Duty Nursing care given on an outpatient basis by a licensed nurse such as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N).

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

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

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

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

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

At Highmark's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three-year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

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

Reconstructive Procedures

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

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

Benefits for Reconstructive Procedures *include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry*. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact the Claims Administrator (Highmark) Customer Service phone number on the back of your ID card for more information about Benefits for mastectomy-related services.

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

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does

not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please remember that **you must obtain Prior Authorization** from Healthcare Management Services **five business days BEFORE** undergoing a Reconstructive Procedure. When **you** *obtain Prior Authorization***,** Healthcare Management Services can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always **excluded** from coverage. ***Call the phone number on the back of your ID card.*** Also see the Well Connected (Case Management) section earlier in this SPD.

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

- physical therapy;
- occupational therapy;
- speech therapy;
- post-cochlear implant aural therapy;
- vision therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

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

Prior Authorization is required for Out-of-Network Physical, Speech and Occupational Therapy.

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

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Habilitative Services. (Federal Legislation - Essential Health Benefits). The Essential Health Benefits (EHB) provision of the Affordable Care Act (ACA) introduced a new coverage category for Habilitative services (physical therapy, speech therapy, occupational therapy).

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.

An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Scopic Procedures - Outpatient Diagnostic and Therapeutic
The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

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

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

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

Second Surgical Opinion
Covered at 100% for up to two (i.e., a second opinion and third opinion).

Second Surgical Opinion Review. Second Surgical Opinion Review may be required for inpatient surgeries when using Out-of-Network providers. If you are seeking care from a Network physician, the physician will contact Highmark.

You must contact Highmark if a second opinion is required. If a second opinion is required, Highmark can assist you with the names of up to three doctors in your area from which you can choose to provide the second opinion. The cost for this opinion is covered at 100% and is not subject to the Annual Deductible.

If you fail to obtain a second surgical opinion when advised to do so and Highmark determines that your surgery is not a covered health service, your benefits may be denied. If the first reviewing physician agrees with the treating physician that the proposed inpatient surgery is appropriate, then Highmark will authorize payment. If the first reviewing physician does not agree with the treating physician that the proposed inpatient surgery is appropriate, then you may request a third opinion from a physician of your choice as to whether the proposed procedure is appropriate. If approved in advance by Highmark, the cost for this opinion is covered at 100% and is not subject to the Annual Deductible.

If you do not request the second physician review, or the second physician review differs from that of the first reviewing physician, Highmark shall determine whether the proposed inpatient surgery is a covered health service. UnitedHealthcare in their determination will take into account the opinions of the treating physician and the first reviewing physician.

Even if a second opinion is required, the final decision about whether you should have surgery is up to you and your doctor, not Highmark. However, if Highmark determines that your surgery is not a covered service, plan benefits could be denied.

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

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

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

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

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

Benefits are available only if:

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

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

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

You are expected to improve to a predictable level of recovery.

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

Any combination of Network Benefits and Out-of-Network Benefits is limited to 120 days per calendar year.

Prior Authorization is required for Skilled Nursing Facility/Inpatient Rehabilitation Facility services.

Please remember **you must obtain Prior Authorization** from Healthcare Management Services as follows:
■ for elective admissions: **five business days BEFORE admission**;
■ for Emergency admissions (also termed non-elective admissions): **as soon as is reasonably possible.**
If Prior Authorization from Healthcare Management Services is not obtained as stated above, Benefits for the extended stay will be subject to a $150 reduction. ***Call the phone number on the back of your ID card.***

Spinal Treatment
The Plan pays Benefits for Spinal Treatment when provided by a Network or Out-of-Network Spinal Treatment specialist in the specialist's office. Covered Health Services include chiropractic and osteopathic manipulative therapy.

The Plan gives the Claims Administrator (Highmark) the right to deny Benefits if treatment ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or recurring.

Benefits include diagnosis and related services. The Plan limits any combination of Network Benefits for Spinal Treatment to one visit per day up to 20 visits per calendar year.

Substance Use Disorder Services
Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.

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

- diagnostic evaluations and assessment;
- treatment planning;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management;
- crisis intervention; and
- detoxification.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment; and
- services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

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

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

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

Prior Authorization is required for Special Substance Use Disorder Programs and Services.

Please remember for Out-of-Network Benefits, **you must obtain Prior Authorization** from the MH/SUD Administrator **in** advance to receive these Benefits. Please refer to the *Healthcare Management Services* section for the specific services that require Prior Authorization. **Without Prior Authorization, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Surgery - Outpatient
The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

Prior Authorization is required for diagnostic catheterization and electrophysiology implant and sleep apnea outpatient surgeries.

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

Temporomandibular Joint Dysfunction (TMJ)
The Plan covers diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect or pathology.

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

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

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

Benefits under this section include:

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

Prior Authorization is required for dialysis, intensity modulated radiation therapy, and MR-guided focused ultrasounds.

Transplantation Services
Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. Benefits are available to the donor and the recipient when the recipient is covered

under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven.

Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

Benefits are also available for cornea transplants. You are not required to notify Highmark or Healthcare Management Services of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility. Therefore, cornea transplants are not eligible for Travel and Lodging Benefits.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

Note: *Transplant services for Knee and Hip Replacement, Spine Surgery and Cardiac Care are covered at* ***100%*** *if performed at a* ***Blue Distinction Plus*** *Center.*

The Plan has specific guidelines regarding Benefits for transplant services. Contact Highmark at the Customer Service phone number on the back of your ID card for information about these guidelines.

Prior Authorization is required for Transplantation services.

Please remember **you must obtain Prior Authorization from** Healthcare Management Services **as soon as the possible (ASAP)** of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). **If Prior Authorization from Healthcare Management Services is not obtained ASAP, Benefits will be subject to a $150 reduction.** ***Call the phone number on the back of your ID card.***

Note: *The services described under Travel and Lodging are Covered Health Services only in connection with Transplantation services when received* ***at a Designated Facility.***

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

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

Travel and lodging expenses are only available if the recipient lives more than 100 miles from the Blue Distinction Center Facility/Center of Excellence. The Claims Administrator (Highmark) must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

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

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

Support in the event of serious illness
If you or a covered family member has cancer or needs an organ or bone marrow transplant, the Claims Administrator (Highmark) can put you in touch with quality treatment centers around the country.

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

Wigs
The Plan pays Benefits for wigs and other scalp hair prosthesis **only** for loss of hair resulting from chemotherapy treatment.

WELL CONNECTED INCENTIVE PROGRAM AND RESOURCES TO HELP YOU STAY HEALTHY

The Plan believes in giving you the tools you need to be an educated health care consumer. In addition, we are providing incentives and resources to help you stay on track and make it a rewarding experience.

Highmark (BCBS) Wellness Programs (without Incentives)
Blues On Call
Blues On Call, our comprehensive health information and support program, provides you with up-to-date, easy to understand information about medical conditions and treatment options.

A registered nurse Health Coach is available online at your Highmark BlueCross BlueShield member web site or at a toll-free telephone number – 1-888-BLUE-428 – 24 hours a day, seven days a week to help you make informed health care decisions, optimize your self-care capabilities, and follow your prescribed treatment plans to improve your health outcomes. Using the patient-centered approach, Shared Decision-Making, Blues On Call offers three levels of health coaching and support:

- General information and support regarding medical procedures, treatment decisions and questions following a doctor's visit, plus access to audiotapes on hundreds of health-related topics and targeted mailings of printed materials.
- Treatment decision support for making medical and surgical decisions that reflect personal values and preferences, talking with physicians regarding treatment options, and receiving ongoing support and follow-up throughout treatment plans, plus links to information sources, free videotapes and web-based education.
- Chronic condition management for those at greater risk for hospitalization, complications or an increase in the severity of their disease, including needs assessments, information on effectively managing a chronic condition, and referrals to appropriate resources, such as case managers, home health services, community resources or Employee Assistance Programs. Blues On Call also provides targeted mailings relative to specific risks, free equipment or tools to support self-management goals and help to improve clinical and quality of life outcomes and reduce ongoing risks associated with chronic disease.

Blues On Call wellness coaching programs offer you one-on-one support from a wellness coach to help you change your health behavior. Wellness coaches partner with you to:

- Recognize the impact your lifestyle choices have on your health
- Realize the Benefits of changing your lifestyle to improve your health and quality of life
- Identify any barriers to change you might have
- Learn to use tools to help you make changes
- Build skills, motivation and self-confidence to make changes last

Wellness coaches tailor programs to you, so you can be successful in changing health behaviors and reducing the risk of lifestyle-related diseases, while helping you overcome resistance to change. During scheduled phone calls, the wellness coach guides you through a personal assessment, helps you set goals, provides ongoing support and motivation, reviews your progress and provides strategies to overcome barriers to success.

You may choose from five wellness coaching programs:

- **Simply Well** – a nutrition program that promotes a balanced approach to healthy eating to help you improve your overall health and well-being. A wellness coach teaches you the basics of healthy eating, including how to make the right food choices, and encourages you to improve eating habits over time.
- **Aim for Change** – a weight management program that supports long-term weight management through a balanced approach to nutrition and physical activity. Coaches guide you through the process of understanding the components of a healthy lifestyle, improving eating habits and food choices, and incorporating physical activity to achieve and sustain weight loss.
- **Get Moving** – a physical activity program that educates you about the Benefits of exercise to your health, fitness and well-being. Coaches motivate you to develop, engage in and sustain a comprehensive physical activity program.
- **Restoring Balance** – a stress management program that teaches you about stress and how it impacts your overall health and well-being. Coaches introduce skills, strategies and relaxation techniques to increase resilience to stress and make behavioral changes to improve your ability to cope with everyday stresses.
- **Tobacco Cessation** – a tobacco cessation program conducted by a trained professional who helps tobacco users quit at their own pace. Coaches provide individual support, behavior modification, support coping with withdrawal, stress management and weight management.

Treatment While Traveling

Your coverage is in effect 24-hours a day, anywhere in the world. If traveling and your condition is life threatening, **seek treatment immediately.** You can go to any hospital for care. See “Emergency care” in the summary of covered services section for the steps to follow in a life-threatening emergency.

Highmark Website

As a Highmark member, you have a wealth of health information at your fingertips. And now it’s easier than ever to access all your online offerings. Whether you are

looking for a health care provider or managing your claims want to make informed health care decisions on treatment options or lead a healthier lifestyle, Highmark can help with easy-to-use online tools and resources.

Go to **www.highmarkbcbs.com**. Then click on the "Log in" link to your homepage to take advantage of all these health tools:

- **"Coverage":** you can get coverage information, access member discounts and request replacement ID cards.
- **"Claims":** you can view your claims, track your health care costs and get information about the costs of medical services.
- **"Spending":** you can research cost saving tools, submit covered expenses, and access our forms library.
- **"Find a Doctor":** you can access our provider directory which includes a wide range of information on doctors, hospitals and other providers.
- **"Your Wellness":** you can utilize WebMD® health services for secure and personalized tools to manage your health.

Highmark realizes the importance of a healthy lifestyle. Our goal is to help you reach your healthiest potential. That's why, in addition to our website wellness tools, we keep you informed via your quarterly member newsletter, *Looking Healthward*. This newsletter contains new product updates, as well as a variety of health and preventive ***care articles and "stay healthy" tips.***

Baby BluePrints
If you are expecting a baby, this is an exciting time for you. It's also a time when you have many questions and concerns about you and your developing baby's health.

To help you understand and manage every stage of pregnancy and childbirth, Highmark offers the Baby BluePrints Maternity Education and Support Program.

By enrolling in this free program, you will have access to printed and online information on all aspects of pregnancy and childbirth. Baby BluePrints will also provide you with personal support from a nurse Health Coach available to you throughout your pregnancy. And you'll be sent valuable gifts for participating.

Just call toll-free at 866-918-5267. You can enroll at any time during your pregnancy. Once you enroll, you will receive a Welcome Package that includes:

- A comprehensive Maternity Guide with important health information;
- A guide to educational resources found on your member website;
- Flyers on available discount programs/services;
- A Childbirth Education Class Reimbursement form; and
- Vouchers for the three free gifts:
    - Gift at initial enrollment – choice of book on pregnancy/childcare;

- Gift at the end of the second trimester – baby photo album; and
- Gift after delivery – Child's dish set and book on Child emergency and first aid care.

If you have any questions about Baby BluePrints, please call Member Service at the number on your ID card. We encourage you to enroll early in your pregnancy to take full advantage of this exciting program.

EXCLUSIONS: PLAN BENEFITS NOT COVERED

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition. The exclusions listed below apply to the *Plan Benefits* section and are subject to change from time to time and overtime. In addition, exclusions from coverage listed in the *Exclusions: Prescription Drug Plan Benefits Not Covered* section also apply to this section.

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

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limiting to", it is not the Claims Administrator's (Highmark) intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to." This list changes from time to time and over time. To assure that a service or product is a Covered Expense, contact the number on the back of your ID card for approval.

Alternative Treatments

1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and

6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Spinal Treatment and non-manipulative osteopathic care for which Benefits are provided as described in the *Additional Benefit Coverage Details* section. This exclusion does not apply to services provided by a naturopath acting within the scope of his or her license.

Comfort and Convenience
Supplies, equipment and similar incidentals for personal comfort. Examples include:

1. television;

2. telephone;

3. air conditioners;

4. beauty/barber service;

5. guest service;

6. air purifiers and filters;

7. batteries and battery chargers; (unless it is associated with a medical device/procedure that is considered medically necessary);

8. dehumidifiers and humidifiers;

9. ergonomically correct chairs;

10. electric scooters;

11. non-Hospital beds and comfort beds;

12. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in the *Additional Benefit Coverage Details* section; and

13. home remodeling to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

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

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

Endodontics, periodontal surgery and restorative treatment are excluded.

2. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered dental in nature, including oral appliances;

3. preventive dental care;

4. diagnosis or treatment of the teeth or gums. Examples include:

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

5. dental implants and braces;

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

   This exclusion does not apply to dental sedation and general anesthesia when a Physician determined to be medically necessary for which Benefits are available under the Plan, as identified in the *Additional Benefit Coverage Details* section; and

7. treatment of malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Drugs

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

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

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

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

4. over the counter drugs and treatments.

Enteral Nutrition (Formula)
This Benefit does not cover food of any kind. Foods that are not covered include:

1. enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU), unless they are the only source of nutrition. Infant formula available over the counter is always excluded;

2. foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;

3. oral vitamins and minerals;

4. meals you can order from a menu, for an additional charge, during an Inpatient Stay; and

5. other dietary and electrolyte supplements;

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

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

Foot Care
1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in the *Additional Benefit Coverage Details* section. Routine foot care services that are not covered include:

   - cutting or removal of corns and calluses;
   - nail trimming or cutting; and
   - debriding (removal of dead skin or underlying tissue);

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

   - cleaning and soaking the feet;

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

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;

4. treatment of subluxation of the foot;

5. shoe inserts when not prescribed by a Physician;

6. arch supports when not prescribed by a Physician;

7. shoes (standard or custom), lifts and wedges when not prescribed by a Physician; and

8. shoe orthotics when not prescribed by a Physician.

Gender Dysphoria
Services considered not medically necessary will be denied. The following procedures are considered cosmetic and generally are not covered when not medically necessary. This list includes but is not limited to:

1. treatment received outside of the United States;

2. reproduction services, including but not limited to: sperm preservation in advance of hormone treatment or gender dysphoria surgery, cryopreservation of fertilized embryos, ooctye preservation, surrogate parenting, donor eggs, donor sperm and host uterus;

3. drugs for hair loss or growth;

4. drugs for sexual performance for patients that have undergone genital reconstruction;

5. voice Therapy;

6. transportation, meals, lodging, or similar expenses;

7. reversal of genital surgery or reversal of surgery to revise secondary sex characteristics;

8. reduction of Thyroid Chondroplasty (reduction of Adam’s Apple);

9. voice modification surgery;
10. suction-assisted lipoplasty of the waist, hips, or thighs;
11. body Contouring;
12. brow Lift;
13. calf Implants;
14. Liposuction
15. Removal of redundant skin
16. Rhinoplasty
17. Breast Augmentation
18. Nipple/areola reconstruction
19. Mastopexy
20. Rhytidectomy
21. Blepharaoptosis
22. Blepharoplasty
23. Hair Removal – electrolysis or laser hair removal
24. Hair transplantation
25. Facial feminizing (eg. facial bone reduction)
26. Chin augmentation
27. Lip reduction/enhancement
28. Cricothyoid approximation
29. Trachea shave/reduction thyroid chondroplasty
30. Layngoplasty
31. Collegen Injections
32. cheek, Chin, Nose implants; and
33. injection of fillers or neurotoxin

Please contact UnitedHealthcare for more details regarding this benefit.

Medical Supplies and Appliances

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

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

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

   This exclusion does not apply to:

   - ostomy bags and related supplies for which Benefits are provided as described under Ostomy Supplies in the Additional Benefit Coverage Details section;
   - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under Durable Medical Equipment in the Additional Benefit Coverage Details section; or
   - diabetic supplies for which Benefits are provided as described under Diabetes Services in the Additional *Benefit Coverage Details* section.

3. tubings, nasal cannulas, connectors and masks that are not used in connection with DME.

4. orthotic appliances that straighten or re-shape a body part (including some types of braces). Examples of excluded orthotic appliances and devices include, but are not limited to, foot orthotics when not prescribed by a Physician or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

5. cranial banding;

6. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in the *Additional Benefit Coverage Details* section.

Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services, Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders* and/or *Substance Use Disorder Services* in the *Additional Benefit Coverage Details* section.

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

2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
   - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
   - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
   - Not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time.
   - Not clinically appropriate for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.
   - Custodial in nature and are being provided primarily to assist with activities of daily living or that are primarily for the purpose of protective detention.

3. Services or supplies that do not meet the definition of a Covered Health Service – see the definition in the *Glossary*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator (Highmark) determines to be all of the following:
   - Medically Necessary.
   - Described as a Covered Health Service in this Plan.
   - Not otherwise excluded in this Plan under Exclusions.

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

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

6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.

7. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

8. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.

9. Learning, motor disorders and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

10. Intellectual disabilities as a primary diagnosis defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

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

12. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

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

14. Intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder.

15. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition and Health Education

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

2. nutritional counseling for either individuals or groups, except as identified under *Diabetes Services*, and except as defined under *Nutritional Counseling* in the *Additional Benefit Coverage Details* section;

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

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

4. health club memberships and programs, and spa treatments; and

5. health education classes unless offered by the Claims Administrator (Highmark) or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Physical Appearance

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

    - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
    - pharmacological regimens;
    - nutritional procedures or treatments;
    - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures); and
    - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;

2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation;

3. wigs except for chemotherapy treatment, in which case the Plan pays up to a maximum of one wig per Covered Person per lifetime; and

4. treatments for hair loss;

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

6. varicose vein treatment of the lower extremities, when it is considered cosmetic; and

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

Pregnancy and Infertility

1. surrogate parenting expenses (non-Covered Person);

2. the reversal of voluntary sterilization;

3. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;

4. impregnation or fertilization charges for surrogate donor (actual or attempted);

5. prenatal, labor and delivery coverage for Dependent Children;

6. elective surgical, non-surgical or drug induced Pregnancy termination;

   This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, or missed abortion (commonly known as a miscarriage), incest or rape. *(**Note:** Only incest or rape would apply to services for a Dependent Child)*

7. services provided by a doula (labor aide);

8. parenting, pre-natal or birthing classes; and

9. Cryopreservation.

Providers
Services:

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

2. a provider may perform on himself or herself;

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

4. ordered or delivered by a Christian Science practitioner;

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

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

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

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

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

   This exclusion does not apply to mammography testing.

Services Provided under Another Plan
Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in the *Coordination of Benefits (COB* section);

2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;

3. while on active military duty; and

4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants,

   - except as identified under *Transplantation Services* in the *Additional Benefit Coverage Details* section;
   - determined by Health Management Services not to be proven procedures for the involved diagnoses; and
   - not consistent with the diagnosis of the condition;

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

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

Travel

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

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

Vision and Hearing

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

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

3. purchase cost and associated fitting charges for eyeglasses or contact lenses;

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

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

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

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

All Other Exclusions

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition. The exclusions listed below are subject to change from time to time and over time.

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

2. charges for:

   - missed appointments;
   - room or facility reservations;
   - completion of claim forms;
   - record processing; or
   - services, supplies or equipment that are advertised by the Provider as free;

3. charges by a Provider sanctioned under a federal program for reason of fraud, abuse or medical competency;

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

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

6. Custodial Care as defined in the *Glossary* section, or services provided by a personal care assistant;

7. diagnostic tests that are:

   - delivered in other than a Physician's office or health care facility; and

- self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;

8. Domiciliary Care, as defined in the *Glossary* section;

9. growth hormone therapy, except for dwarfism secondary to pituitary gland failure;

10. expenses for health services and supplies:

    - that do not meet the definition of a Covered Health Service in the *Glossary* section;
    - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
    - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
    - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
    - that exceed Eligible Expenses or any specified limitation in this SPD;
    - for which a Out-of-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;

11. foreign language and sign language services;

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

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

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

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

15. private duty nursing received on an inpatient basis;

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

17. rest cures;

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

19. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, Sickness, stroke, cancer, autism spectrum disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant as identified under *Rehabilitation Services – Outpatient Therapy and Spinal Treatment* in the *Additional Benefit Coverage Details* section;

20. Spinal Treatment to treat a condition unrelated to alignment of the vertebral column, such as asthma or allergies;

21. storage of blood, umbilical cord or other material for use in a Covered Health Service, except if needed for an imminent surgery;

22. the following treatments for obesity:

    - non-surgical treatment, even if for morbid obesity; and
    - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* in the *Additional Benefit Coverage Details* section; and

23. treatment of hyperhidrosis (excessive sweating); and

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

PRESCRIPTION DRUG BENEFITS

Prescription Drug Coverage Highlights

Within this Section, references to the Claims Administrator (UHC) only refer to UnitedHealthcare. The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy (after your deductible has been met). For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section. Pharmacy copay will apply to the annual Out-of-Pocket Maximum.

Covered Health Services[1]	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	**Out-of-Network**
Retail[2] - up to a 30-day supply		
• tier-1	100% after you pay a: $10 Copay; OR 100% for Influenza vaccines or diabetic supplies	100% after you pay a: $10 Copay; OR 100% for Influenza vaccines or diabetic supplies
• tier-2	70% after you pay a: minimum Copay of $35 and a maximum Copay of $60; OR 100% for Influenza vaccines or diabetic supplies	70% after you pay a: minimum Copay of $35 and a maximum Copay of $60; OR 100% for Influenza vaccines or diabetic supplies
• tier-3	55% after you pay a: minimum Copay of $50 and a maximum Copay of $100; OR 100% for Influenza vaccines or diabetic supplies	55% after you pay a: minimum Copay of $50 and a maximum Copay of $100; OR 100% for Influenza vaccines or diabetic supplies.
Retail Pharmacy Maintenance Prescription Drugs	**After 2 fills at a retail pharmacy, you will need to refill your maintenance medication prescriptions with OptumRx Mail Service Pharmacy or you will pay the full cost of the medication. See Mail Order copays below.**	
Mail Order - up to 90-day supply		
• tier-1	$25 Copay	Not Available
• tier-2	$80 Copay	Not Available

Covered Health Services[1]	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	**Out-of-Network**
• tier-3	$140 Copay	Not Available
• Specialty Prescription Drugs - up to 30-day supply		
• tier 1	$15 Copay	Not Available
• tier 2	$65 Copay	Not Available
• tier 3	$125 Copay	Not Available

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

[2]The Plan pays Benefits for Specialty Prescription Drugs as described in the above table.

Note: The Coordination of Benefits provision described in the *Coordination of Benefits (COB)* section does **not** apply to covered Prescription Drugs as described in this section. Prescription Drug Benefits will not be coordinated with those of any other health coverage plan.

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

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

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

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

Each tier is assigned a Copay and/or Coinsurance, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay and/or Coinsurance will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

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

Coinsurance for a Prescription Drug at a Network Pharmacy is a percentage of the Prescription Drug Charge. Coinsurance for a Prescription Drug at a Out-of-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.

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

- the applicable Copay and/or Coinsurance;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Charge that the Claims Administrator (UHC) agreed to pay the Network Pharmacy.

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

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

Retail
The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting the Claims Administrator (UHC) Customer Service at the phone number on the back your ID card or by logging onto **www.myuhc.com.**

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

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed;
- for a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied:
- Infertility drugs are covered up to a limit of $200 annually.

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

Mail Order
You will need to use OptumRx Mail Service pharmacy for most maintenance medications. Through OptumRx® Mail Service Pharmacy, you receive convenient, safe and reliable service, including:

- Delivery of up to a 3-month supply of your medication right to your mailbox
- Flexible delivery anywhere in the U.S. with no charge to you for standard shipping
- Educational information about your prescriptions with each shipment
- Access to pharmacists 24 hours a day, seven days a week to answer your medication questions

In order to transition, you will be allowed only 2 fills before you will need to use OptumRx Mail Service pharmacy for most maintenance medications. After two fills at a participating retail pharmacy, you must begin ordering your maintenance prescriptions through the ***mail order or you will begin to pay the full cost of the medication.***

The 100% cost will not apply to your Out-of-Pocket Maximum and will not be a covered claim. **You will continue to pay this cost even if you have met your Out- of-Pocket Maximum unless you switch to mail order.**

This applies to many maintenance medications with the exception of specialty, compounds and controlled substances. Please refer to **www.myuhc.com** for information on specific drugs which apply to the mail service program. You may also contact the member services phone number on the back of your health plan ID card.

Getting Started

Option 1: Call the member phone number listed on the back of your health plan ID card.

Member Services is available 24 hours a day, seven days a week to help you start using mail service. Please have your medication name and doctor's telephone number ready when you call.

Option 2: Talk to your doctor before your prescriptions must be switched to OptumRx.

Tell your doctor you want to use OptumRx for home delivery of your maintenance medications. Be sure to ask for a new prescription written for up to a 3-month supply with three refills to maximize your plan benefits. Then you can either:

- Mail in your written prescriptions along with a completed order form.
- Ask your doctor to call 1-800-791-7658 with your prescriptions or to fax them to 1-800-491-7997.

Option 3 Log on to www.myuhc.com

You can get started by

- Clicking on "Manage My Prescriptions" and selecting "Transfer Prescriptions"
- Select the medications you would like to transfer
- Print out the pre-populated form and bring this to your doctor
- Ask your doctor to call or fax in the prescriptions with the order form

Once OptumRx receives your complete order for a new prescription, your medications should arrive within ten business days - completed refill orders should arrive in about seven business days. If you need your medication right away, ask your doctor for a 1-month supply that can be immediately filled at a participating retail pharmacy. You can avoid this step by allowing sufficient time for your prescriptions to be moved to OptumRx.

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

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

These supply limits do not apply to Specialty Prescription Drugs. Specialty Prescription Drugs from a mail order Network Pharmacy are subject to the supply limits stated above under the heading Specialty Prescription Drugs.

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

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

Designated Pharmacy
If you require certain Prescription Drugs, the Claims Administrator (UHC) may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Please see the *Prescription Drug Glossary* in this SPD for definitions of *Designated Pharmacy.*

Specialty Prescription Drugs
You may fill a prescription for Specialty Prescription Drugs up to two times at any Pharmacy. However, after that you will be directed to a Designated Pharmacy and if you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid, and you will be responsible for paying all charges.

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the tables at the beginning of this section for details on Specialty Prescription Drug supply limits.

***Note*: To lower your Out-of-Pocket Prescription Drug costs:** Consider tier-1 Prescription Drugs, if you and your Physician decide they are appropriate.

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

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

Economic factors may include:

- the acquisition cost of the Prescription Drug; and

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

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

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

The PDL Management Committee may periodically change the placement of a Prescription Drug among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to you. This means you should carefully review with your prescribing physician whether a Prescription Drug is covered and if so, at what tier. You can also call the number on the back of your ID card to obtain this information.

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

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

Notification Requirements
Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to notify the Claims Administrator (UHC). The Claims Administrator (UHC) will determine if the Prescription Drug, in accordance with UnitedHealthcare approved guidelines, is both:

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

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

Network Pharmacy Notification
When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for notifying the Claims Administrator (UHC).

Out-of-Network Pharmacy Notification
When Prescription Drugs are dispensed at a Out-of-Network Pharmacy, you or your Physician are responsible for notifying the Claims Administrator (UHC) as required.

If the Claims Administrator (UHC) is not notified before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Charge) will not be available to you at an Out-of-Network Pharmacy. If the Claims Administrator (UHC) is not notified before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see the *Claims Procedures* section for information on how to file a claim.

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

To determine if a Prescription Drug requires notification, either visit **www.myuhc.com** or call Customer Service at the number on the back of your ID card. The Prescription Drugs requiring notification are subject to the Claims Administrator's (UHC) periodic review and modification.

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

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

Prescription Drug Benefit Claims
For Prescription Drug claims procedures, please refer to the *Claims Procedures* section.

Limitation on Selection of Pharmacies
If the Claims Administrator (UHC) determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of

Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator (UHC) will select a single Network Pharmacy for you.

Supply Limits
Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call Customer Service at the number on the back of your ID card. Whether or not a Prescription Drug has a supply limit is subject to the Claims Administrator's (UHC) periodic review and modification.

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

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

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

Special Programs
CenturyLink and the Claims Administrator (UHC) may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling Customer Service at the number on the back of your ID card.

Smoking Cessation Products
Coverage for prescription smoking cessation products (including Chantix, Bupropion, Nicotrol, and Zyban) are covered at 100% by the Plan for up to 90 days per calendar year. You must be enrolled in the Quit For Life® program to be eligible for these products as a covered Benefit. See the Well Connected section above for more information.

Prescription Drug Products Prescribed by a Specialist Physician
You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug was prescribed by a specialist physician. You may access information on which Prescription Drugs are subject to Benefit enhancement, reduction or no Benefit through the Internet at **www.myuhc.com** or by calling the telephone number on your ID card.

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

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

My ScriptRewards
Provides members select medications to treat HIV infection at $0 cost share. The $0 cost share medications include: Cimduo, Cimduo plus Isentress, OR Cimduo plus Tivicay. In addition, members who fill the $0 cost share combination products will be eligible for up to $500 in prepaid debit cards to offset medical expenses. HIV is the first medication category to be part of the My ScriptRewards program.
Benefits:

• Guides the member to the most cost effective, guideline recommended regimen
• Lowest out of pocket cost for the member

Members can call 833-854-6523 for more information and to join the program."

Rebates and Other Discounts
The Claims Administrator (UHC) and CenturyLink may, at times, receive rebates for certain drugs on the PDL. The Claims Administrator (UHC) **does not** pass these rebates and other discounts on to you. Nor does the Claims Administrator (UHC) take them into account when determining your Copays and Coinsurance.

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

Coupons, Incentives and Other Communications

The Claims Administrator (UHC) may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition. It is important to note that if you use a manufacturer coupon or copay card for Specialty medications, the amount paid by the manufacturer on your behalf will not apply to your deductible or out of pocket maximums. Only your true out of pocket costs will apply to your deductible or out of pocket maximums.

EXCLUSIONS - PRESCRIPTION DRUG PLAN BENEFITS NOT COVERED

The exclusions listed below apply to the *Prescription Drug Plan* section. In addition, exclusions from coverage listed in the *Exclusions Plan Benefits* section also apply to this section.

When an exclusion applies to only certain Prescription Drugs, you can access **www.myuhc.com** through the Internet or by calling the phone number on the back of your ID card for information on which Prescription Drugs are excluded. This listing is subject to change and is updated from time to time and over time.

Medications that are:

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

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

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

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

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

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

7. for smoking cessation unless enrolled in the Quit Tobacco® program. Supply limits apply;

8. growth hormone for Children with familial short stature based on heredity and not caused by a diagnosed medical condition);

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

10. the amount dispensed (day's supply or quantity limit) which is less than the minimum supply limit;

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

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

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

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

15. Prescription Drugs, including new Prescription Drugs or new dosage forms, that UnitedHealthcare determines do not meet the definition of a Covered Health Service;

16. Prescription Drugs that contain an approved biosimilar or a biosimilar and Therapeutically Equivalent (having essentially the same efficacy and adverse effect profile) to another covered Prescription Drug;

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

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

19. unit dose packaging of Prescription Drugs;

20. in a particular Therapeutic Class (visit **www.myuhc.com** or call the phone number on the back of your ID card for information on which Therapeutic Classes are excluded;

21. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless the Claims Administrator (Highmark) and CenturyLink have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in the *Glossary* section;

22. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed. However: Replacement Prescription Drugs are automatically available for catastrophes and natural disasters, such as floods and earthquakes. *(**Note**: You have the option to appeal if an excluded drug is prescribed for a specific medical condition. Please reference the Claims Procedures section below for more information.);*

23. used for cosmetic purposes; and

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

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

CLAIMS PROCEDURES

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

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

Out-of-Network Benefits
If you receive a bill for Covered Health Services from a Out-of-Network provider, you (or the provider if they prefer) must send the bill to the Claims Administrator (Highmark) for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to the Claims Administrator (Highmark) at the address on the back of your ID card. The Claims Administrator's (Highmark) address is also shown in the *Claims Administrator (Highmark) and Contact Information* section.

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

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

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

How To File Your Claim
You can obtain a claim form by visiting **www.highmarkbcbs.com** or calling Customer Service at the number on the back of your ID card or contacting CenturyLink Service Center for Health and Welfare Benefits. If you do not have a claim form, simply attach a brief letter of explanation to the bill and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Retiree;
- the number as shown on your ID card;

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

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

The above information should be filed with the Claims Administrator (Highmark) at the address on your ID card. When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy Benefit manager claims address noted on your ID card.

After the Claims Administrator (Highmark) has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Out-of-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

The Claims Administrator (Highmark) will pay Benefits to you unless:

- the provider notifies the Claims Administrator (Highmark) that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the Out-of-Network provider to be paid directly at the time you submit your claim.

The Claims Administrator (Highmark) will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider has assigned Benefits to that third party.

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

Important - Timely Filing of Out-of-Network Claims
All claim forms for Out-of-Network **services must be submitted within 12 months after the date of service**. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by the Claims Administrator (Highmark). This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

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

When appealing a denied claim, please be aware that there are *Service Claim* appeals processed by the Claims Administrator (Highmark) as well as *Eligibility/Participation* appeals processed by the Plan Administrator. Both types of appeal have two levels of appeal processing each with their own requirements as described below.

How to Appeal a Denied Service Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your Level 1 appeal in writing within 180 days of receiving the claim denial which is also called an “adverse Benefit determination”. You do not need to submit Urgent Care appeals in writing. Your appeal of a denied claim should include:

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

Note*: If you are appealing an excluded drug, submit a letter to UHC from your doctor stating the medical condition that requires the non-covered drug and the length of projected use. The appeal will be reviewed and, if approved, you will be able to purchase your prescription at your local network pharmacy or by mail order*

by paying the applicable Copay amount. If it is denied, you may appeal as explained below.

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

Highmark BCBS
Attention: Claims
P. O. Box 3355
Pittsburgh, PA 15230-0007

For Urgent Care requests for Benefits that have been denied, you or your provider can call the Claims Administrator (Highmark) Customer Service number on the back of your ID card to request an appeal.

Types of claims
The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:
- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal
The Claims Administrator (Highmark) will conduct a full and fair review of your appeal. The appeal may be reviewed by:

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

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

Filing a Second Appeal
There are offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator (Highmark) within 60 days from receipt of the first level appeal determination.

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

Federal External Review Program
If, after exhausting your internal appeals, you are not satisfied with the determination made by the Claims Administrator (Highmark), or if the Claims Administrator (Highmark) fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of the Claims Administrator's (Highmark) determination.

You may request an external review of an adverse Benefit determination if the denial is based upon any of the following:

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

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. **Please Note this Deadline:** A request must be made within four (4) months after the date you received the Claims Administrator's (Highmark) decision.

An external review request should include all of the following:

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

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

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

Standard External Review
A standard external review is comprised of all of the following:

- a preliminary review by the Claims Administrator (Highmark) of the request;

- a referral of the request by the Claims Administrator (Highmark) to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, [the Claims Administrator (Highmark) will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

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

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

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

The Claims Administrator (Highmark) will provide to the assigned IRO the documents and information considered in making the Claims Administrator's (Highmark) determination. The documents include:

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

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

of Final External Review Decision to you and the Claims Administrator (Highmark), and it will include the clinical basis for the determination.

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

Expedited External Review

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

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

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

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

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

After the Claims Administrator (Highmark) completes the review, the Claims Administrator (Highmark) will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, the Claims Administrator (Highmark) will assign an IRO in the same manner the Claims

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

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

You may contact the Claims Administrator (Highmark) Customer Service phone number on the back of your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

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

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

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

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is incomplete, the Claims Administrator (Highmark) must notify you within:	**24 hours**

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

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

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	**Timing**
If your request for Benefits is filed improperly, the Claims Administrator (Highmark) must notify you within:	**5 days**
If your request for Benefits is incomplete, the Claims Administrator (Highmark) must notify you within:	**15 days**
You must then provide completed request for Benefits information to the Claims Administrator (Highmark) within:	**45 days**
The Claims Administrator (Highmark) must notify you of the Benefit determination:	
• if the initial request for Benefits is complete, within:	**15 days**

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	**Timing**
• after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	**15 days**
You must appeal an adverse Benefit determination (file a first level appeal) no later than:	**180 days** after receiving the adverse Benefit determination
The Claims Administrator (Highmark) must notify you of the first level appeal decision within:	**15 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator (Highmark) must notify you of the second level appeal decision within:	**15 days** after receiving the second level appeal

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

Post-Service Claims	
Type of Claim or Appeal	**Timing**
The Claims Administrator (Highmark) must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Claims Administrator (Highmark) must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

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

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

Eligibility/Participation Claim
After you receive an initial denial of a submitted claim, there are **two** levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from the Claims Administrator (Highmark) within 180 days from the receipt of the first level appeal determination. The below Table outlines both the timeline for filing an appeal by you and for receiving responses from the Claims Administrator (Highmark).

Eligibility/Participation Claims	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, the Claims Administrator (Highmark) must notify you within:	**30 days**
You must then provide completed claim information to the Claims Administrator (Highmark) within:	**45 days**
The Claims Administrator (Highmark) must notify you of the benefit determination:	
• if the initial claim is complete, within:	**30 days**
• after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal an adverse benefit determination no later than (First Level appeal):	**180 days** after receiving the adverse benefit determination
The Claims Administrator (Highmark) must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**180 days** after receiving the first level appeal decision
The Claim Administrator (Highmark) must notify you of the second level appeal decision for eligibility/participation claim within:	**60 days** after receiving the second level appeal (up to an additional 30 days may be required if necessary)

Time Deadline to File a Benefit Claim and the Time Deadline to File a Benefit-Related Lawsuit

The Health Plan provides that no person has the right to file a civil action, proceeding or lawsuit against the Health Plan or any person acting with respect to the Health Plan, including, but not limited to, the Company, any Participating Company, the Committee or any other fiduciary, or any third party service provider unless it is filed within the timing explained as follows below:

Initial Claim: The time frame for filing an initial claim for a premium Payroll Adjustment is the earlier of:

(1) Within 180 days of an adverse decision by the Plan Administrator, or

(2) The earlier of:

a. Within 180 days of the effective date of an election that is later claimed to be erroneous, or

b. By the last day of the Plan Year of when the election error is claimed to have occurred. If the initial claim is not filed by this deadline, it shall be deemed untimely and denied on that basis. Appeals from a claim denial must also be timely filed as described in the Summary Plan Description.

Legal Action Deadline: After you have exhausted or completed the claims and appeals procedures as explained above, you may pursue any other legal remedy, such as bringing a lawsuit or civil action in court provided, that you file a civil action, proceeding or lawsuit against the Plan or the Plan Administrator or the Claims Administration no later than the last day of the twelfth month following the later of (1) the deadline for filing an appeal under the Plan or (2) the date on which an adverse benefit determination on appeal was issued to you with respect to your Plan benefit claim.

This means that you cannot bring any legal action against the Plan, the Employee Benefits Committee or the Claims Administrator (Highmark) for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action, you must do so no later than the last day of the 12th month from the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan or the Claims Administrator (Highmark).

COORDINATION OF BENEFITS (COB)

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

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

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its Benefits first, without regard to the possibility that another plan may cover some

expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its Benefits based on the Benefits paid by the primary plan.

Remember: Update your Dependents' Medical Coverage Information to avoid delays on your Dependent claims. Just log on to **www.highmarkbcbs.com** (as identified on the back of your ID card) or call the Customer Service number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

See the *General Information SPD* for more details regarding Coordination of Benefits.

Coordination with Military Benefits

While you are on a military leave of absence, the military Benefits for which you are eligible will be the Primary payor. However, if your Dependents participate under the Plan while you are on military leave, the Plan coverage is primary; any military coverage for them will be secondary to the Plan. ***See the General Information SPD for more details regarding Military status provisions*.**

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 Claims Administrator (Highmark) may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining Benefits payable under this Plan and other plans covering the person claiming Benefits.

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

Overpayment and Underpayment of Benefits

See the General Information SPD regarding provisions for COB overpayment and underpayments due to multiple plan payments.

SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. The terms of this entire subrogation and reimbursement provision shall apply, and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any

potentially responsible party and regardless of whether the settlement or judgment received by the Covered Individual identifies the medical benefits the Plan advanced. The Plan's right of full reimbursement shall not be reduced or limited in any way by the Covered Individual's actual or alleged comparative fault or contributory negligence in causing the injury(ies) or accident for which the Plan advanced medical benefits.

See the General Information SPD for more details regarding the Plan's right of recovery or Subrogation.

GENERAL ADMINISTRATIVE PROVISIONS

This section summarizes the legal information about the Plan. For more information refer to the *General Information SPD*.

Plan Document

This Benefits Summary presents an overview of your Benefits. In the event of any discrepancy between this summary and the official *Plan Document*, the *Plan Document* shall govern.

Records and Information and Your Obligation to Furnish Information

At times, the Plan or the Claims Administrator (Highmark) may need information from you. You agree to furnish the Plan and/or the Claims Administrator (Highmark) with all information and proofs that are reasonably required regarding any matters pertaining to the Plan, including eligibility and Benefits. If you do not provide this information when requested, it may delay or result in the denial of your claim.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you, to furnish the Plan or the Claims Administrator (Highmark) with all information or copies of records relating to the services provided to you. The Plan or the Claims Administrator (Highmark) has the right to request this information at any reasonable time as well as other information concerning your eligibility and Benefits. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the enrollment form.

The Plan agrees that such information and records will be considered confidential. We and the Claims Administrator (Highmark) have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as we are required by law or regulation.

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

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

In some cases, we and the Claims Administrator (Highmark) will designate other persons or entities to request records or information from or related to you and will release those records as necessary. Our designees have the same rights to this information as we have.

During and after the term of the Plan, we and our related entities may use and transfer the information gathered under the Plan, including claim information for research, database creation, and other analytic purposes.

Interpretation of Plan
The Plan Administrator, and to the extent it has delegated to the Claims Administrator (Highmark), have sole and exclusive authority and discretion in:

- Interpreting Benefits under the Plan
- Interpreting the other terms, conditions, limitations, and exclusions set out in the Plan, including this SPD
- Determining the eligibility, rights, and status of all persons under the Plan
- Making factual determinations, finding and determining all facts related to the Plan and its Benefits
- Having the power to decide all disputes and questions arising under the Plan

The Plan Administrator and to the extent it has delegated to the Claims Administrator (Highmark) may delegate this discretionary authority to other persons or entities who provide services in regard to the administration of the Plan.

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

Right to Amend and Right to Adopt Rules of Administration
The Plan Administrator, the CenturyLink Employee Benefits Committee, may adopt, at any time, rules and procedures that it determines to be necessary or desirable with respect to the operation of the Plans. The Company, in its separate and distinct role as the Plan Sponsor has the right, within its sole discretion and authority, at any time to amend, modify, or eliminate any Benefit or provision of the Plan or to not amend the Plan at all, to change contribution levels and/or to terminate the Plan, subject to all applicable laws. The Company has delegated this discretion and authority to amend, modify or terminate the Plan to the CenturyLink Plan Design Committee.

Clerical Error
If a clerical error or other mistake occurs, however occurring, that error does not create a right to Benefits. Clerical errors include, but are not limited to, providing misinformation on eligibility or Benefit coverages or entitlements or relating to information transmittal and/or communications, perfunctory or ministerial in nature, involving claims processing, and recordkeeping. Although every effort is and will be made to administer the Plan in a fully accurate manner, any inadvertent error, misstatement or omission will be disregarded, and the actual Plan provisions will be controlling. A clerical error will not void coverage to which a Participant is entitled under the terms of the Plan, nor will it continue coverage that should have ended under the terms of the Plan. When an error is found, it will be corrected or adjusted appropriately as soon as practicable. Interest shall not be payable with respect to a Benefit corrected or adjusted. It is your responsibility to confirm the accuracy of statements made by the Plan or our designees, including the Claims Administrator(Highmark), in accordance with the terms of this SPD and other Plan Documents.

Administrative Services
The Plan may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing and utilization management services. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Examination of Covered Persons
In the event of a question or dispute regarding Benefits, the Plan may require that a Physician of the Plan's choice examine you at our expense.

Workers' Compensation Not Affected
Benefits provided under the Health Plan do not substitute for and do not affect any requirements for coverage by Worker's Compensation insurance.

Conformity with Statutes
Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions not otherwise preempted by ERISA (of the jurisdiction in which the Plan is delivered), is hereby amended to conform to the minimum requirements of such statutes and regulations. As a self-funded plan, the Plan generally is not subject to State laws and regulations including, but not limited to, State law Benefit mandates.

Incentives to You
At various times the Claims Administrator (Highmark) may offer coupons or other incentives to encourage you to participate in various wellness programs or certain

disease management programs. The decision about whether or not you choose to participate is yours alone, but you should discuss participating in such programs with your Provider. These incentives are not Plan Benefits and do not alter or affect your Benefits. Contact the Claims Administrator (Highmark) if you have any questions.

Incentives to Providers

The Plan and the Claims Administrator (Highmark) do not provide health care services or supplies, nor does CenturyLink or the Plan Administrator practice medicine. Rather, the Claims Administrator (Highmark) arranges for Providers to participate in a Network. Network Providers are independent practitioners; they are not CenturyLink Employees or Employees of the Claims Administrator (Highmark), nor is there any other relationship with Network Providers such as principal-agent or joint venture. Each party is an independent contractor.

The Plan arranges payments to Network Providers through various types of contractual arrangements. These arrangements may include financial incentives by the Plan or the Claims Administrator (Highmark) to promote the delivery of health care in a cost efficient and effective manner. Such financial incentives are not intended to impact your access to health care. Examples of financial incentives for Network Providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost effectiveness

- Capitation is when a group of Network Providers receives a monthly payment for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the health care is less than or more than the payment

- Risk-sharing payments – the Network provider is paid a specific amount for a particular unit of service, such as an amount per day, an amount per stay, an amount per episode, an amount per case, an amount per period of illness, an amount per Covered Person or an amount per service with targeted outcome. If the amount paid is more than the cost of providing or arranging a Covered Person's health services, the Network provider may keep some of the excess. If the amount paid is less than the cost of providing or arranging a Covered Person's health service, the Network provider may bear some of the shortfall

- Various payment methods to pay specific Network Providers are used. From time to time, the payment method may change. If you have questions about whether your Network Provider's contract includes any financial incentives, we encourage you to discuss those questions with your Provider. You may also contact the Claims Administrator (Highmark) at the telephone number on your ID card. The Claims Administrator (Highmark) can advise whether your

Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed

Refund of Benefit Overpayments
If the Plan pays Benefits for expenses incurred by a Covered Person, that Covered Person, or any other person or organization that was paid, must refund the overpayment if:

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

- All or some of the payment we made exceeded the cost of Benefits under the Plan
- All or some of the payment was made in error.

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future Benefits including issuing you a Form 1099 for the amount of the overpayment as gross income.

Additionally, if the Covered Person was determined not to be eligible for the Benefits under the Plan, that individual must refund the amount of the excess Benefit payment and the Plan may undertake collection actions, subject to the requirements of applicable law.

Your Relationship with the Claims Administrator (Highmark) and the Plan
In order to make choices about your health care coverage and treatment, the Plan believes that it is important for you to understand how the Claims Administrator (Highmark) interacts with the Plan Sponsor's Benefit Plan and how it may affect you. The Claims Administrator (Highmark) helps administer the Plan Sponsor's Benefit plan in which you are enrolled. The Claims Administrator (Highmark) does not provide medical services or make treatment decisions. This means:

- the Plan and the Claims Administrator (Highmark) do not decide what care you need or will receive. You and your Physician make those decisions;

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

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

Relationship with Providers

The relationships between the Plan, the Claims Administrator (Highmark) and Network providers are solely contractual relationships between independent contractors. Network providers are not CenturyLink's agents or Employees, nor are they agents or Employees of the Claims Administrator (Highmark). CenturyLink and any of its Employees are not agents or Employees of Network providers, nor are the Claims Administrator (Highmark) and any of its Employees agents or Employees of Network providers.

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

The Claims Administrator (Highmark) is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of Benefits under this Plan.

The Plan Administrator is responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and

- notifying you of the termination or modifications to the Plan.

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

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with UnitedHealthcare to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some UHC products. Refer to your provider directory or contact UnitedHealthcare for assistance.

Rebates and Other Payments
The Plan and the Claims Administrator (Highmark) may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. The Plan and the Claims Administrator (Highmark) **do not** pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Copays or Coinsurance.

GLOSSARY MEDICAL

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan. ***In addition to this Glossary, there are also terms defined within the document and in the General Information SPD*.**

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

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

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Plan amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a calendar year before the Plan will begin paying Benefits in that calendar year. The Deductible is shown in the first table in the Plan *Highlights* section.

Annual Enrollment – the period of time, determined by CenturyLink, during which eligible retired Employees may enroll themselves and their eligible Dependents under the Plan. CenturyLink determines the period of time that is the Annual Enrollment period.

Autism Spectrum Disorders – a group of neurobiological disorders that includes *Autistic Disorder*, *Rhett's Syndrome*, *Asperger's Disorder*, *Childhood Disintegrated Disorder*, and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Blues On Call – the primary nurse that the Claims Administrator (Highmark) may assign to you if you have a chronic or complex health condition. If a Blues on Call nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Body Mass Index (BMI) – a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

BMI – see Body Mass Index (BMI).

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – Highmark & OptumRX the organizations that provide certain claim administration and other services for the Plan. *Refer to the Claims Administrator (Highmark) and Contact Information Table near the beginning of this SPD.*

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in the *PPO Plan Features and How the Plan Works* section.

Company – CenturyLink, Inc.

Complications of Pregnancy – a condition suffered by a Dependent Child that requires medical treatment before or after Pregnancy ends.

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

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a Child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain retired Employees and their covered Dependents whose group health insurance has been terminated. ***Refer to the General Information SPD for more information.***

Copayment (or Copay) – the set dollar amount you are required to pay for certain Covered Health Services as described in the *PPO Plan Features and How the Plan Works* section.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator (Highmark). Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services or supplies, which Highmark determines to be medically necessary and:

- provided for the purpose of preventing, diagnosing or treating Sickness, Injury, Mental Illness, Substance Use Disorders, or their symptoms;
- included in the Plan Highlights and Additional Benefit Coverage Details sections;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described in this SPD and in the *General Information SPD*; and
- not identified in the *Exclusions* section.

The Claims Administrator (Highmark) maintains clinical protocols that describe the scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. You can access these clinical protocols (as revised from time to time) on **www.highmarkbcbs.com** or by calling the number on the back of your ID card. This information is also available to Physicians and other health care professionals on this same website.

Covered Person – either the eligible Retiree or an enrolled eligible Dependent as defined by the Plan and only while such person(s) enrolled and eligible for Benefits under the Plan as defined in the *General Information SPD*. References to "you" and "your" throughout this SPD are references to a Covered Person. ***See the General Information SPD for more details.***

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described in the *General Information SPD*. A Dependent does not include anyone who is also enrolled as an Employee/Retiree. No one can be a Dependent of more than one Employee/Retiree.

Designated Facility – a facility that has entered into an agreement with the Claims Administrator (Highmark) or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility, including but not limited to Centers of Excellence (COE), may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same or opposite sex with whom you have established a domestic partnership as described in the *General Information SPD.*

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

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

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable, other than the diabetic supplies and inhaler spacers specifically stated as covered;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Health Services that are provided while the Plan is in effect and, determined by the Claim's Administrator (Highmark).

Eligible Expenses are determined solely in accordance with the Claims Administrator's (Highmark) reimbursement policy guidelines. The Claims Administrator (Highmark) develops the reimbursement policy guidelines, in the Claims Administrator's (Highmark) discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

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

For Services Provided by a:	Eligible Expenses are Based On:
Network Provider	Contracted rates with the provider
Out-of-Network Provider	• negotiated rates agreed to by the Out-of-Network provider and either the Claims Administrator (Highmark) or one of its vendors, affiliates or subcontractors, at the discretion of the Claims Administrator (Highmark). ***Note:*** *Out-of-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described above.*

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of a Copay and/or Coinsurance.

Eligible Expenses are subject to the Claims Administrator's (Highmark) reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator (Highmark).

Emergency – a serious medical condition or symptom (including severe pain) resulting from Injury, Sickness or Mental Illness, or substance use disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or jeopardy to life or health, including with respect to a pregnant woman, the health of the woman or her unborn child.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency that are within the capabilities of the staff and facilities available at the Hospital.

Employee – meets the eligibility requirements specified in the Plan, as described under *Eligibility* in the *Introduction* section. An Employee must live and/or work in the United States. The determination of whether an individual who performs services for the Company is an Employee of the Company or an independent contractor and the determination of whether an Employee of the Company was classified as a member of any classification of Employees shall be made in accordance with the classifications used by the Company, in its sole discretion, and not the treatment of the individual for any purposes under the Code, common law, or any other law.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal law that regulates retirement and employee welfare Benefit plans maintained by employers.

Employer – CenturyLink, Inc.

EOB – see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator (Highmark) makes a determination regarding coverage in a particular case, are determined to be any of the following:

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

Exceptions:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the Claims Administrator (Highmark) may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator (Highmark) must determine that, although unproven, the

service has significant potential as an effective treatment for that Sickness or condition.

Alternate Care Proposals (ACP):

Provides appropriate and cost effective health care services and supply alternatives that would otherwise not be covered by the plan.

CenturyLink consents for United Healthcare's use and administration of the ACP program and delegates to United Healthcare the sole discretion and authority to develop and revise ACP's as appropriate.

Explanation of Benefits (EOB) – a statement provided by the Claims Administrator (Highmark) to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - Gender Dysphoria - A disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

Diagnostic criteria for adults and adolescents:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.

- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

Diagnostic criteria for children:

- A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
  - A strong dislike of ones' sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

Healthcare Management Services – programs provided by the Claims Administrator (Highmark) that focus on prevention, education, and closing the gaps

in care designed to encourage an efficient system of care for you and your covered Dependents.

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

Hospital – an institution, operated as required by law, which is:

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

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

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

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

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

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

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Long-term Acute Care Facility (LTAC) – a facility or hospital that provides care to people with complex medical needs requiring long-term hospital stay in an acute or critical setting.

Medical Necessity (Medically Necessary)—see Prior Authorization.

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

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

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

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by The Plan who provides or arranges Mental Health and Substance Use Disorder Services under the Plan. The Administrator for this plan is Highmark.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in the *Exclusions* section.

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

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a Out-of-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Plan Highlights* section for details about how Network Benefits apply.

Out-of-Network Benefits - description of how Benefits are paid for Covered Health Services provided by Out-of-Network providers. Refer to the *Plan Highlights* section for details about how Out-of-Network Benefits apply.

Out-of-Pocket Maximum – the maximum amount you pay every calendar year. Refer to the *Plan Highlights* section for the Out-of-Pocket Maximum amount. See the *PPO Plan Features and How the Plan Works* section for a description of how the Out-of-Pocket Maximum works.

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

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

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

Plan – The Retiree and Inactive Health Plan.

Plan Administrator – CenturyLink Employee Benefits Committee and its designees.

Plan Sponsor – CenturyLink, Inc.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Primary Physician – a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Primary Physician.

Prior Authorization – Advanced approval to receive health care services deemed medically necessary by the Claim's Administrator. These are healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms including surgically implanted medical devices, that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;

- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.
- if you and/or a covered dependent have had services including medical devices approved in the past by UnitedHealthcare and have had a recent medical condition change which results in an increase of pain, device malfunction (including battery replacement) and/or deteriorating medical condition, the services must be reviewed to determine if they are covered under the plan in order for the device to be repaired or replaced. Recent and sufficient clinical data must be provided in order for coverage to be determined

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on **www.myuhc.com** or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcare Online.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;

- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

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

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

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

Retired Employee – an Employee who is eligible for retiree health coverage under the CenturyLink Retiree and Inactive Health Plan and who retires while covered under the Plan as described in the *General Information SPD. See the Retiree and Inactive Health Plan SPD for more information.*

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is

necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - a program in which UnitedHealthcare may obtain a discount to a Out-of-Network provider's billed charges. This discount is usually based on a schedule previously agreed to by the Out-of-Network Provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UnitedHealthcare. In this case the Out-of-Network provider may bill you for the difference between the billed amount and the rate determined by UnitedHealthcare. If this happens you should call the number on your ID Card. Shared Savings Program providers are not Network providers and are not credentialed by UnitedHealthcare.

Short-term Acute Care Facility – a facility or hospital that provides care to people with medical needs requiring short-term hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden sickness, injury, or flare-up of a chronic sickness.

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

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine. For Mental Health Services and Substance Use Disorder Services, any licensed clinician is considered on the same basis as a Specialist Physician.

Spinal Treatment – the therapeutic application of chiropractic and/or spinal treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Spouse – an individual to whom you are legally married as defined in the *General Information SPD*.

Sub-acute facility – a facility that provides intermediate care on a short-term or long-term basis.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded.

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

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

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

The Claims Administrator Highmark) has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Claims Administrator (Highmark) issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at **www.highmarkbcbs.com**.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), the Claims Administrator (Highmark) may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, the Claims Administrator (Highmark) must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.
- The Claims Administrator (Highmark) may, in its discretion, consider an otherwise Unproven Service to be a Covered Health Service for a Covered Person with a Sickness or Injury that is not life-threatening. For that to occur, all of the following conditions must be met:
  - If the service is one that requires review by the *U.S. Food and Drug Administration* (FDA), it must be FDA-approved.
  - It must be performed by a Physician and in a facility with demonstrated experience and expertise.
  - The Covered Person must consent to the procedure acknowledging that the Claims Administrator (Highmark) does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
  - At least two studies from more than one institution must be available in published peer-reviewed medical literature that would allow the Claims Administrator (Highmark) to conclude that the service is promising but unproven.
  - The service must be available from a Network Physician and/or a Network facility.

The decision about whether such a service can be deemed a Covered Health Service is solely at the Claims Administrator's (Highmark) discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are at a location, distinct from a hospital emergency department, an office or a clinic;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

GLOSSARY - PRESCRIPTION DRUGS

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

Brand-name - a Prescription Drug that is either:

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

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

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

Generic - a Prescription Drug that is either:

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

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

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

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

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

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee of the Claims Administrator (UHC).

Predominant Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a Out-of-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a Out-of-Network Pharmacy includes a dispensing fee and any applicable sales tax. The Claims Administrator (UHC) calculates the Predominant Reimbursement Rate using its Prescription Drug Charge that applies for that particular Prescription Drug at most Network Pharmacies.

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

- inhalers (with spacers);
- insulin;

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

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

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

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

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

Therapeutic Class – a group or category of Prescription Drug with similar uses and/or actions.

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

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