Archdiocese of St. Louis

Summary Plan Document

for

UnitedHealthcare Choice Plus Standard Plan

Group Number: 703597
Effective Date: July 1, 2013

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Introduction

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

How to Use this Document

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

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

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

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

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Information about Defined Terms

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

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

Your Contribution to the Benefit Costs

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

Customer Service and Claims Submittal

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

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

Prior Notification: Please refer to the Customer Service number shown on your ID card.

Mental Health/Substance Use Disorder Services Designee: Please refer to the Customer Service number shown on your ID card.

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Claims Submittal Address:

United HealthCare Services, Inc.

PO Box 30555

Salt Lake City, Utah 84130-0555

Requests for Initial Appeals of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

United HealthCare Services, Inc.

PO Box 30432

Salt Lake City, Utah 84130-0432

Requests for Final Appeals of Denied Claims and Notice of Complaints:

Name and Address For Submitting Requests:

Archdiocese Benefits Council

Archdiocese of St. Louis – HR Benefits

20 Archbishop May Drive

St. Louis, Missouri 63119

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Section 1: What's Covered – Benefits

The Following Should be Noted:

This section provides you with information about:

- Accessing Benefits.
- Copayments and Eligible Expenses.
- Annual Deductible and Out-of-Pocket Maximum.
- Covered Health Services. We pay Benefits for the Covered Health Services described in this section unless they are listed as not covered in (Section 2: What's Not Covered--Exclusions).
- Covered Health Services that require you or your provider to notify the Claims Administrator before you receive them. In general, Network providers are responsible for notifying the Claims Administrator before they provide certain health services to you. You are responsible for notifying the Claims Administrator before you receive certain health services from a non-Network provider.

Accessing Benefits

Depending on the geographic area and the service you receive, you may have access through the Claims Administrator's Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, and if your Copayment is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers, because the Eligible Expense may be a lesser amount.

Copayment

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

Eligible Expenses

Eligible Expenses are the amount that we will pay for Benefits, as determined by us or by our designee. In almost all cases our designee is the Claims Administrator. For a complete definition of Eligible Expenses that describes how payment is determined, see (Section 10: Glossary of Defined Terms).

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

When you receive Covered Health Services from Network providers, you are not responsible for any difference between the Eligible Expenses and the amount the provider bills. When you receive Covered Health Services from non-Network providers, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses.

Notification Requirements

Prior notification is required before you receive certain Covered Health Services. In general, Network providers are responsible for notifying the Claims Administrator before they provide these services to you. There are some Network Benefits, however, for which you are responsible for notifying the Claims Administrator.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for notifying us before you receive these Covered Health Services.

Services for which you must provide prior notification appear in this section under the *Must You Notify the Claims Administrator*? column in the table labeled *Benefit Information*.

To notify the Claims Administrator, call the telephone number on your ID card.

When you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services, even if not indicated in the *Must You Notify the Claims Administrator?* column. That's because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

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

Special Note Regarding Medicare

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

Special Note Regarding Mental Health and Substance Use Disorder Services

You must provide pre-service notification as described below.

When Benefits are provided for any of the services listed below, the following services require notification:

- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility): intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; outpatient treatment provided in your home.
- Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders -inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

For a scheduled admission, you must notify the Mental Health/Substance Use Disorder Administrator prior to the admission, or as soon as reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be subject to a Plan Level Penalty Deductible of $300.

In addition, you must notify the Mental Health/Substance Use Disorder Administrator before the following services are received. If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, Benefits will be subject to a Plan Level Penalty Deductible of $300. Services requiring prior notification are:

- Intensive outpatient program treatment.
- Outpatient electro-convulsive treatment.
- Psychological testing.
- Outpatient treatment of opioid dependence.
- Extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

Special Mental Health and 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 Mental Health Services benefit. The Mental Health Services and Substance Use Disorder Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness and 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.

Payment Information

Payment Term	Description	Amounts
Annual Deductible	The amount you pay for Covered Health Services before you are eligible to receive Benefits. For a complete definition of Annual Deductible, see (Section 10: Glossary of Defined Terms). Any Covered Expenses used during the months of October, November and December to satisfy the Individual Deductible will be used to satisfy the Individual Deductible for the following Calendar Year.	***Network*** $1,000 per Covered Person per calendar year, not to exceed $2,000 for all Covered Persons in a family. ***Non-Network*** $2,000 per Covered Person per calendar year, not to exceed $4,000 for all Covered Persons in a family.
Out-of-Pocket Maximum	The maximum you pay, out of your pocket, in a calendar year for percentage Copayments. For a complete definition of Out-of-Pocket Maximum, see (Section 10: Glossary of Defined Terms).	***Network*** $3,000 per Covered Person per calendar year, not to exceed $6,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible or fixed dollar Copayments. ***Non-Network*** $6,000 per Covered Person per calendar year, not to exceed $12,000 for all Covered Persons in a family. The Out-of-Pocket Maximum does not include the Annual Deductible or fixed dollar Copayments.

Payment Term	Description	Amounts
Maximum Plan Benefit	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.	***Network and Non-Network*** No Maximum Plan Benefit.

Benefit Information

The Following Should be Noted:

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
1. Ambulance Services - Emergency only Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency Health Services can be performed.	***Network*** No	*Ground Transportation:* 20% *Air Transportation:* 20%	Yes	Yes
	Non-Network No	Same as Network	Same as Network	Same as Network
2. Cancer Resource Services We will arrange for access to certain of our Network providers that participate in the Cancer Resource Services Program for the provision of oncology services. We may refer you to Cancer Resource Services, or you may self refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of Benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.	***Network*** Cancer Resource Services must be called.	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
In order to receive Benefits under this program, Cancer Resource Services must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. When these services are not performed in a Cancer Resource Services facility, Benefits will be paid the same as Benefits for *Hospital-Inpatient Stay, Outpatient Surgery, Diagnostic and Therapeutic Services, Physician's Office Services*, and *Professional Fees for Surgical and Medical Services* stated in this (Section 1: What's Covered--Benefits).				
	Non-Network Non-Network Benefits for the Cancer Resource Services Program are not available.	Non-Network Benefits for the Cancer Resource Services Program are not available.	Non-Network Benefits for the Cancer Resource Services Program are not available.	Non-Network Benefits for the Cancer Resource Services Program are not available.
3. Dental Services - Accident only Dental services when all of the following are true: • Treatment is necessary because of accidental damage. • Dental services are received from a Doctor of Dental Surgery, "D.D.S." or Doctor of Medical Dentistry, "D.M.D.". • The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.	***Network*** Yes	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was: • A virgin or unrestored tooth, or • A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: • Started within three months of the accident. • Completed within 12 months of the accident. Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an "accident". Benefits are not available for repairs to teeth that are injured as a result of such activities. **Notify the Claims Administrator** Please remember that you must notify the Claims Administrator as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. (You do not have to provide notification before the initial Emergency treatment.) If you don't notify the Claims Administrator prior to receiving the service will result in a Plan Level Penalty Deductible of $300.	***Non-Network*** Yes	Same as Network	Same as Network	Same as Network

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
4. Durable Medical Equipment Durable Medical Equipment that meets each of the following criteria: • Ordered or provided by a Physician for outpatient use. • Used for medical purposes. • Not consumable or disposable. • Not of use to a person in the absence of a disease or disability. If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the most cost-effective piece of equipment. Examples of Durable Medical Equipment include: • Equipment to assist mobility, such as a standard wheelchair. • A standard Hospital-type bed. • Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks). • Delivery pumps for tube feedings (including tubing and connectors). • Ostomy Supplies. • Braces, 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	***Network*** No ***Non-Network*** Yes, for items more than $1,000.	20% 40%	Yes Yes	Yes Yes

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.

- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage).
- Breast Pumps
  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. Benefits are only available if breast pumps are obtained from a DME Provider or Physician.

We provide Benefits only for a single purchase (including repair/ replacement) of a type of Durable Medical Equipment once every three calendar years and for initial placement only.

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

We and the Claims Administrator will decide if the equipment should be purchased or rented. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor the Claims Administrator identifies.

Notify the Claims Administrator

Please remember that for Non-Network Benefits you must notify

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
the Claims Administrator before obtaining any single item of Durable Medical Equipment that costs more than $1,000 (either purchase price or cumulative rental of a single item). If you don't notify the Claims Administrator, you will be responsible for paying all charges and no Benefits will be paid.				
5. Emergency Health Services Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. You will find more information about Benefits for Emergency Health Services in (Section 3: Description of Network and Non-Network Benefits). **Notify the Claims Administrator** To ensure prompt and accurate payment of your claim as a Network Benefit, notify the Claims Administrator within two business days or as soon as possible after you receive outpatient Emergency Health Services at a non-Network Hospital or Alternate Facility. Please remember that if you are admitted to a non-Network Hospital as a result of an Emergency, you must notify the Claims Administrator within one business day or the same day of admission, or as soon as reasonably possible.	***Network*** No ***Non-Network*** Yes, but only for an Inpatient Stay.	$150 per visit. Copayment waived if admitted as Inpatient beyond 23 hours. Same as Network	No Same as Network	No Same as Network

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
If you don't notify the Claims Administrator, Benefits for the non-Network Hospital Inpatient Stay will result in a Plan Level Penalty Deductible of $300. Plan Level Penalty Deductible will not apply for the outpatient Emergency Health Services.				

6. Hearing Aids

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. Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in the Certificate, only for Covered Persons who have either of the following: • Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid. • Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.	***Network*** No	20%	Yes	Yes
Any combination of Network and Non-Network Benefits for hearing aids is limited to $5,000 in Eligible Expenses per year.	***Non-Network***			

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits are limited to a single purchase (including repair/replacement) every three years.	Yes	40%	Yes	Yes

7. Home Health Care

Services received from a Home Health Agency that are both of the following: • Ordered by a Physician. • Provided by or supervised by a registered nurse in your home.	***Network*** No	20%	Yes	Yes
Benefits are available only when the Home Health Agency services are provided on a part-time, intermittent schedule and when skilled care is required. Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true: • It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient. • It is ordered by a Physician. • It is not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair. • It requires clinical training in order to be delivered safely and effectively. • It is not Custodial Care.	***Non-Network*** Yes	40%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
We and the Claims Administrator will decide if skilled care is required by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver. Any combination of Network and Non-Network Benefits is limited to 100 visits per calendar year. One visit equals four hours of skilled care services. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator prior to receiving the service will result in a Plan Level Penalty Deductible of $300.				
8. Hospice Care Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members. Benefits are available when hospice care is received from a licensed hospice agency. Please contact the Claims Administrator for more information regarding guidelines for hospice care. You can contact the Claims Administrator at the telephone number on your ID card. Any combination of Network and Non-Network Benefits is limited to	***Network*** No ***Non-Network*** Yes	20% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
360 days during the entire period of time you are covered under the Plan. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. If you don't notify the Claims Administrator prior to receiving the service will result in a Plan Level Penalty Deductible of $300.				
9. Hospital - Inpatient Stay Inpatient Stay in a Hospital. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator as follows: • For elective admissions: five business days before admission. • For non-elective admissions: within one business day or the same day of admission. • For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible. If you don't notify the Claims Administrator prior to receiving the	***Network*** No ***Non-Network*** Yes	20% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
service will result in Plan Level Penalty Deductible of $300.				
10. Infertility Services Medically necessary services for the treatment of infertility benefits is limited to the following: • X-ray and laboratory examinations performed for diagnosing sickness or injury; • Office visits for diagnosing sickness or injury; • Prescription medication (i.e. fertility drugs, hormonal drugs); • Ultrasounds and laboratory tests required to monitor prescribed medication.	***Network*** No	20%	Yes	Yes
	Non-Network Yes	40%	Yes	Yes
11. Injections received in a Physician's Office Benefits are available for injections received in a Physician's office when no other health service is received, for example allergy immunotherapy.	***Network*** No	$30 per visit. No Copayment applies when a Physician charge is not assessed.	No	No
	Non-Network No	40% per injection	Yes	Yes
12. Maternity Services Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-	***Network*** No	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
related medical services for prenatal care, postnatal care, delivery, and any related complications.			Therapeutic Services.	
There are special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the programs. To sign up, you should notify the Claims Administrator during the first trimester, but no later than one month prior to the anticipated childbirth. We will pay Benefits for an Inpatient Stay of at least: • 48 hours for the mother and newborn child following a normal vaginal delivery. • 96 hours for the mother and newborn child following a cesarean section delivery. If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.		No Copayment applies to Physician office visits for prenatal care after the first visit.		
Notify the Claims Administrator Please remember that for Non-Network Benefits you must notify the Claims Administrator as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than the time frames described. If you don't notify the Claims Administrator that the Inpatient Stay will be extended will result in a Plan Level Penalty Deductible of $300.	***Non-Network*** Yes if Inpatient Stay exceeds time frames.	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services.		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
13. 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 an inpatient basis: • Diagnostic evaluations and assessment. • Treatment planning. • Referral services. • Medication management. • Individual, family, therapeutic group and provider-based case management services. • Crisis intervention. Benefits include the following services provided on an inpatient basis: • Partial Hospitalization/Day Treatment. • 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	***Network*** No	**Hospital – Inpatient Stay** 20% **Physician's Office Services** $30 per visit	Yes No	Yes No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis. • You must obtain prior notification through the Mental Health Services in order to receive Benefits. Without notification, Benefits will be subject to a Plan Level Penalty Deductible of $300 *(Non-notification penalty applies to Inpatient Services)*				
	Non-Network Yes	40%	Yes	Yes
14. Morbid Obesity Gastric Bypass/Lap Bands Surgery Requirements: Weight:- BMI of 40 or greater or BMI of 35 or greater with co-morbidity conditions including, but not limited to: Cardiovascular disease including stroke, myocardial infarction, stable or unstable angina pectoris, coronary artery bypass or other procedures. Hyperlipidemia uncontrolled by pharmacotherapy. Type 2 diabetes uncontrolled by pharmacotherapy. Hypertension uncontrolled by pharmacotherapy. Moderate to severe sleep apnea with a respiratory disturbance index (RDI) of 16 to 30 (moderate) or apnea-hypopnea index (AHI) >30 (severe) as documented through the completion of a laboratory based polysomnography)	***Network*** No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Weight Loss Program: Complete a 6 month physician supervised diet. Proof of failed medical therapy including physician-supervised treatment with low calorie diet, lower fat diets, alteration of physical activity patterns, behavioral therapy and pharmacotherapy. At least six months of frequent medical visits of at least once per month and preferably more often to supervise combined dietary, physical activity, and behavioral therapy. Lifestyle change strategies should be attempted prior to the initiation of pharmacotherapy. Documentation of a structured diet program includes physician or other health care provider notes and/or diet or weight loss logs from a structured weight loss program. Assessment: Complete a psychological evaluation prior to surgery. Age: Patient must be between the ages of 18-65				
	Non-Network No	40%	Yes	Yes
15. Natural Family Planning Natural Family Planning (NFP) is a system of understanding a couple's combined fertility through observation of natural changes in the woman's body. Couples may then use this information to avoid	***Network*** No	No Copayment	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
or achieve pregnancy naturally, without using drugs, surgery, or devices. Benefits for Natural Family Planning counseling: There are four covered methods of Natural Family Planning counseling which include the following: • Billings Ovulation Method; • Creighton Model Services; • Sympto-Thermal Method; • Marquette Model. For more information, please contact: Archdiocesan Office of Natural Family Planning (314) 997-7576 website: **www.stlouisnfp.org** Contraceptive drugs are not covered except for medical necessity with a physician diagnosis, participant filing of an appeal and an approved exception by the Archdiocese of St Louis. Call 314.792.7546 for questions.				
	Non-Network No	No Copayment	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
16. Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders	***Network***	**Hospital – Inpatient Stay**		
	No	20%	Yes	Yes
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 an inpatient basis: • Diagnostic evaluations and assessment. • Treatment planning. • Referral services. • Medication management.		**Physician's Office Services** $30 per visit	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Individual, family, therapeutic group and provided-based case management services. • Crisis intervention. Benefits include the following services provided on an inpatient basis: • Partial Hospitalization/Day Treatment. • 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. **Notification Required** Please remember for Non-Network Benefits, you must notify the MH/SUD Administrator to receive these Benefits. Please call the phone number that appears on your ID card.	***Non-Network*** Yes	40%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
You must obtain prior notification through the Mental Health Services in order to receive Benefits. Without notification, Benefits will be subject to a Plan Level Penalty Deductible of $300 *(Non-notification penalty applies to Inpatient Services)*				
17. Nutritional Counseling	***Network***			
Covered Health Services provided by a registered dietician in an individual session for Covered Persons with medical conditions that require a special diet. Examples of such medical conditions include, but are not limited to:	***No***	$30 per visit.	No	No
· Diabetes mellitus.		Outpatient Facility subject to deductible of $250 then 20% coinsurance.	No Yes	Yes Yes
· Coronary artery disease.				
· Congestive heart failure.				
· Severe obstructive airway disease.				
· Gout.				
· Renal failure.				
· Phenylketonuria.				
· Hyperlipidemias.				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits are limited to three individual sessions during a Covered Person's lifetime for each medical condition.				
	Non-Network No	40%	Yes	Yes
18. Ostomy Supplies Benefits for ostomy supplies include only the following: • Pouches, face plates and belts. • Irrigation sleeves, bags and catheters. • Skin barriers.	***Network*** No	20%	Yes	Yes
Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.	***Non-Network*** No	40%	Yes	Yes
19. Outpatient Surgery, Diagnostic and Therapeutic Services				
Outpatient Surgery Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.	***Network*** No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Benefits under this section include only the facility charge and the charge for required Hospital-based professional services, supplies and equipment. Benefits for the surgeon fees related to outpatient surgery are described under *Professional Fees for Surgical and Medical Services*. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***Non-Network*** No	40%	Yes	Yes
Outpatient Diagnostic Services Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including: • Lab and radiology/X-ray. • Mammography testing. Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	***Network*** No	***For lab and radiology/ X-ray:*** No Copayment	No	No
		For mammography testing: No Copayment	No	No
		For Sigmoidoscopies, Colonoscopies, and Endoscopies:: No Copayment	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below. This section does not include Benefits for CT scans, Pet scans, MRIs, or nuclear medicines, which are described immediately below.	***Non-Network*** No	40%	Yes	Yes
Outpatient Diagnostic/Therapeutic Services - CT Scans, Pet Scans, MRI and Nuclear Medicine Covered Health Services for CT scans, Pet scans, MRI, and nuclear medicine received on an outpatient basis at a Hospital or Alternate Facility.	***Network*** No	20%	Yes	Yes
Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.	***Non-Network*** No	40%	Yes	Yes
Outpatient Therapeutic Treatments Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.	***Network*** No	20%	Yes	Yes
Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees. When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.	***Non-Network*** No	40%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
20. Physician's Office Services 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. • With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration • Well-baby and well-child care • Breast Pumps Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of	***Network*** No	No Copayment	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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. Benefits are only available if breast pumps are obtained from a DME Provider or Physician.				
Covered Health Services received in a Physician's office including: • Diagnosis and treatment of a Sickness or Injury. • Routine physical examinations. • Vision and hearing screenings. (Vision screenings do not include refractive examinations to detect vision impairment to determine the need for prescription glasses or contacts.) • Immunizations. • School Physicals.	No	$30 per visit. No Copayment applies when no Physician charge is assessed	No	No
.	***Non-Network*** No	40%	Yes	Yes
21. Private Duty Nursing Private duty nursing given on an outpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.)	***Network*** No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Private duty nursing is a covered benefit unless receiving home health care services.	***Non-Network*** No	40%	Yes	Yes
22. Professional Fees for Surgical and Medical Services Professional fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.	***Network*** No	20%	Yes	Yes
When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* above.	***Non-Network*** No	40%	Yes	Yes
23. Prosthetic Devices External prosthetic devices that replace a limb or an external body part, limited to: • Artificial arms, legs, feet and hands. • Artificial eyes, ears and noses. • Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.	***Network*** No	20%	Yes	Yes
If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic	***Non-Network*** No	40%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
device. Benefits are provided for the replacement of a type of Durable Medical Equipment once every three calendar years. The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years.				
24. Reconstructive Procedures Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function. Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. 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	***Network*** No ***Non-Network*** Yes	Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices. Same as Physician's Office Services, Professional Fees, Hospital-Inpatient Stay, Outpatient Diagnostic and Therapeutic Services, and Prosthetic Devices.		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
reconstructive procedure. Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy related to breast cancer, and reconstruction of the non-affected breast to achieve symmetry. 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 at the telephone number on your ID card for more information about Benefits for mastectomy-related services. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator five business days before receiving services. When you provide notification, the Claims Administrator can verify that the service is a reconstructive procedure rather than a Cosmetic Procedure. Cosmetic Procedures are always excluded from coverage. If you don't notify the Claims Administrator prior to receiving the service will result in a Plan Level Penalty Deductible of $300.				
25. Rehabilitation Services - Outpatient Therapy Short-term outpatient rehabilitation services for: • Physical therapy.	***Network*** No	$30 per visit	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
• Occupational therapy. • Speech therapy. • Pulmonary rehabilitation therapy. • Cardiac rehabilitation therapy. Rehabilitation services must be performed by a licensed therapy provider, under the direction of a Physician. Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment. Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.	***Non-Network*** No	40%	Yes	Yes
26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for: • Services and supplies received during the Inpatient Stay. • Room and board in a Semi-private Room (a room with two or more beds). Please note that Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise	***Network*** No	20%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
required an Inpatient Stay in a Hospital. **Notify the Claims Administrator** Please remember that for Non-Network Benefits you must notify the Claims Administrator as follows: • For elective admissions: five business days before admission. • For non-elective admission: within one business day or the same day of admission. • For Emergency admissions: within one business day or the same day of admission, or as soon as is reasonably possible. If you don't notify the Claims Administrator prior to receiving the service will result in a Plan Level Penalty Deductible of $300.	***Non-Network*** Yes	40%	Yes	Yes
27. Spinal Treatment Benefits for Spinal Treatment when provided by a Spinal Treatment provider in the provider's office.	***Network*** No	20%	Yes	Yes
Benefits include diagnosis and related services and are limited to one visit and treatment per day. Any combination of Network and Non-Network Benefits for Spinal Treatment is limited to $1,000 per calendar year.	***Non-Network*** No	40%	Yes	Yes
28. 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	***Network*** No	*(The Amount We Pay, based on Eligible Expenses)* Same as Physician's Office Services and Hospital - Inpatient Stay		

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
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. • Detoxification (sub-acute/non-medical). Benefits include the following services provided on an inpatient basis: • Partial Hospitalization/Day Treatment. • 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				

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
required, it is covered on a Semi-private Room basis. You must contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.				
Notification Required Please remember for Non-Network Benefits, that you must notify the MH/SUD Administrator to receive these Benefits in advance of any treatment. Please call the phone number that appears on your ID card. Without authorization, Benefits will be subject to a Plan Level Penalty Deductible of $300 *(Non-notification penalty applies to Inpatient Services)*	***Non-Network*** Yes	*(The Amount We Pay, based on Eligible Expenses)* Same as Physician's Office Services and Hospital - Inpatient Stay		
29. Temporomandibular Joint Syndrome Temporomandibular Joint Dysfunction syndrome (including all myofacial pain dysfunction syndromes and other associated disorders): All medical and/or dental treatment or services for the correction of Temporomandibular Joint Dysfunction will be covered.	***Network*** No	20%	Yes	Yes
Any combination of Network and Non-Network non-surgical TMJ Treatment is limited to $1,000 per Covered Person per year. Surgical treatment of TMJ is covered the same as any other medical condition.	***Non-Network*** No	40%	Yes	Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
30. Transplantation Services Covered Health Services for the following organ and tissue transplants when ordered by a Physician. For Network Benefits, transplantation services must be received at a Designated Facility. Benefits are available for the transplants listed below when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service: • Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. • Heart transplants. • Heart/lung transplants. • Lung transplants. • Kidney transplants. • Kidney/pancreas transplants. • Liver transplants. • Liver/small bowel transplants. • Pancreas transplants. • Small bowel transplants. Benefits are also available for cornea transplants that are provided by a Physician at a Hospital. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive	***Network*** Yes ***Non-Network*** Yes	20% 40%	Yes Yes	Yes Yes

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
Network Benefits. Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage. Under the Plan there are specific guidelines regarding Benefits for transplant services. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines. **Notify the Claims Administrator** For Network Benefits you or your Physician must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you do not notify the Claims Administrator, and if the transplantation services are not performed at a Designated Facility, you will be responsible for paying all charges and Network Benefits will not be paid. Non-Network Benefits may be available. Please remember that for Non-Network Benefits you must notify the Claims Administrator as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).				
31. Urgent Care Center Services Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* earlier in this section.	***Network*** No	$50 per visit	No	No

Description of Covered Health Service	Must You Notify the Claims Administrator?	Your Copayment Amount % Copayments are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to Meet Annual Deductible?
	Non-Network			
	No	40%	Yes	Yes

Section 2: What's Not Covered – Exclusions

The Following Should be Noted:

This section contains information about:

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

How We Use Headings in this Section

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

We Do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

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

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in (Section 1: What's Covered--Benefits) or through a Rider to the SPD.

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aroma therapy.
3. Hypnotism.
4. Massage Therapy.
5. Rolfing.
6. Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

B. Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/Barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - — Air conditioners.
   - — Air purifiers and filters.
   - — Batteries and battery chargers.
   - — Dehumidifiers.

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

— Humidifiers.

6. Devices and computers to assist in communication and speech.

C. Dental

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

D. Drugs

See Outpatient Prescription Drug Rider for description of covered drugs (Attachment I).

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications.

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3. Non-injectable medications given in a Physician's office except as required in an Emergency.
4. Over the counter drugs and treatments.

E. Experimental, Investigational or Unproven Services

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

F. Foot Care

1. Routine foot care (including the cutting or removal of corns and calluses).
2 Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include the following:
   — Cleaning and soaking the feet.
   — Applying skin creams in order to maintain skin tone.
   — Other services that are performed when there is not a localized illness, Injury or symptom involving the foot.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoe orthotics.

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

G. Medical Supplies and Appliances

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - — Elastic stockings.
   - — Ace bandages.
   - — Gauze and dressings.
3. Orthotic appliances that straighten or re-shape a body part (including cranial banding and some types of braces).
4. Tubings and masks are not covered except when used with Durable Medical Equipment (as described in Section 1: What's Covered--Benefits).

H. 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 Service* in Section, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
2. 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; or
   - — not clinically appropriate for the patient's Mental Illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.
3. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
4. Mental Health Services as treatment for a primary diagnosis of insomnia other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;
5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);
6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
8. learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

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

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9. mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
10. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
11. intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders; and
12. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

I. Nutrition

1. Megavitamin and nutrition based therapy.
2. Enteral feedings and other nutritional and electrolyte supplements, including infant formula and donor breast milk.

J. Physical Appearance

1. Cosmetic Procedures. See the definition in (Section 10: Glossary of Defined Terms.) Examples include:
   - — Pharmacological regimens, nutritional procedures or treatments.
   - — Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
   - — Skin abrasion procedures performed as a treatment for acne.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure.

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Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in (Section 1: What's Covered--Benefits).

3. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
4. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
5. Wigs except for treatment of chemotherapy or alopecia areata.

K. Providers

1. Services performed by a provider who is a family member by birth or marriage, including Spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services that are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
   - — Has not been actively involved in your medical care prior to ordering the service, or
   - — Is not actively involved in your medical care after the service is received.

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

L. Reproduction

1. Surrogate parenting.
2. The reversal of voluntary sterilization and voluntary sterilization.
3. Health services and associated expenses for elective abortion, which means the directly intended termination of pregnancy before viability (including the interval between conception and implantation of the embryo) or the directly intended destruction of a viable fetus and which includes any procedure whose sole immediate effect is the termination of pregnancy before viability.
4. Contraceptive supplies and services.
5. Fetal reduction surgery.
6. Health services associated with the use of non-surgical or drug-induced Pregnancy termination.
7. Some Infertility Services including Intracytoplasmic Sperm Injection (ICSI), Pronuclear Stage Embyro Transfer (PROST), In-vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), Tubal Embryo Transfer (TET), Assisted Hatching of Embryos, Donor Sperm, Donor Ova, Artificial Insemination by Donor (AID), Artificial Insemination by Husband (AIH), Surrogate Motherhood, Gestational Surrogacy (Host Uterus), Ericsson Method, Microsort, Costs associated with the collection, preparation, or storage of sperm for artificial insemination, including donor fees, travel costs, Tuboplasty and reversal of voluntary sterilization, Infertility Services, which are determined in the sole discretion of the chief Medical Officer to be experimental.
8. Expenses connected with tubal ligation, vasectomy or abortion, as described in the Ethical Religious Directives for Catholic Health Facilities issued by the United States Catholic Conference and approved by the National Conference of Catholic Bishops (November 1, 1994).

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

M. Services Provided under Another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

   If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

N. Transplants

1. Health services for organ and tissue transplants, except those described in (Section 1: What's Covered--Benefits).
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's Benefits under the Plan.)
3. Health services for transplants involving mechanical or animal organs.
4. Transplant services that are not performed at a Designated Facility.
5. Any solid organ transplant that is performed as a treatment for cancer.

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6. Any multiple organ transplant not listed as a Covered Health Service under the heading *Transplantation Health Services* in (Section 1: What's Covered--Benefits).

O. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to covered transplantation services may be reimbursed at our discretion.

P. Vision and Hearing

1. Purchase cost of eye glasses or contact lenses.
2. Fitting charge for eye glasses or contact lenses.
3. Eye exercise therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.
5. Refractive examinations to detect vision impairment for glasses and contacts.
6. 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.
   - — For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.
7. 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 under the Plan.

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8. Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

Q. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in (Section 10: Glossary of Defined Terms).
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
   - — Required solely for purposes of career, sports or camp, travel, employment, insurance, marriage or adoption.
   - — Related to judicial or administrative proceedings or orders.
   - — Conducted for purposes of medical research.
   - — Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
4. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
6. In the event that a non-Network provider waives Copayments and/or the Annual Deductible for a particular health service, no Benefits are provided for the health service for which the Copayments and/or Annual Deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.

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8. Upper and lower jawbone surgery except as required for direct treatment of acute traumatic Injury or cancer. Orthognathic surgery and jaw alignment, except as a treatment of obstructive sleep apnea.
9. Surgical and non-surgical treatment of obesity, except for morbid obesity.
10. Sex transformation operations.
11. Custodial Care.
12. Domiciliary care.
13. Respite care.
14. Rest cures.
15. Psychosurgery.
16. Treatment of benign gynecomastia (abnormal breast enlargement in males).
17. Medical and surgical treatment of excessive sweating (hyperhidrosis).
18. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
19. Oral appliances for snoring, except for purposes of sleep apnea.
20. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, or a Congenital Anomaly.
21. Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
22. Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment.
23. Any charge for services, supplies or equipment advertised by the provider as free.

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24. Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency.
25. Any charges prohibited by federal anti-kickback or self-referral statutes.
26. Any additional charges submitted after payment has been made and your account balance is zero.
27. Any outpatient facility charge in excess of payable amounts under Medicare.
28. Any charges by a resident in a teaching hospital where a faculty Physician did not supervise services.
29. Wisdom teeth removal.

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

Section 3: Description of Network and Non-Network Benefits

The Following Should be Noted:

This section includes information about:

- Network Benefits.
- Non-Network Benefits.
- Emergency Health Services.

Network Benefits

Network Benefits are generally paid at a higher level than Non-Network Benefits. Network Benefits are payable for Covered Health Services which are either of the following:

- Provided by or under the direction of a Network Physician or other Network provider in the Physician's office or at a Network or non-Network facility.
- Emergency Health Services.

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

Comparison of Network and Non-Network Benefits

	Network	Non-Network
Benefits	A higher level of Benefits means less cost to you. See (Section 1: What's Covered--Benefits).	A lower level of Benefits means more cost to you. See (Section 1: What's Covered--Benefits).
Who Should Notify the Claims Administrator for Care Coordination	Network providers generally handle notification for you. However, there are exceptions. See (Section 1: What's Covered--Benefits), under the *Must You Notify the Claims Administrator?* column.	You must notify the Claims Administrator for certain Covered Health Services. Failure to notify results in reduced Benefits or no Benefits. See (Section 1: What's Covered--Benefits), under the *Must You Notify the Claims Administrator?* column.
Who Should File Claims	Not required. We pay Network providers directly.	You must file claims. See (Section 5: How to File a Claim).

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Outpatient Emergency Health Services	Emergency Health Services are always paid as a Network Benefit (paid the same whether you are in or out of the Network). That means that if you seek Emergency care at a non-Network facility, you are not required to meet the Annual Deductible or to pay any difference between Eligible Expenses and the amount the provider bills.

Provider Network

The Claims Administrator arranges for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees or employees of the Claims Administrator. It is your responsibility to select your provider.

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

You will be given a directory of Network providers. However, before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling the Claims Administrator.

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 to provide only certain Covered Health Services, but not all Covered

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Health Services. Some Network providers choose to be a Network provider for only some products. Refer to your provider directory or contact the Claims Administrator for assistance.

Care Coordination[SM]

Your Network Physician is required to notify the Claims Administrator regarding certain proposed or scheduled health services. When your Network Physician notifies the Claims Administrator, they will work together to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

If you receive certain Covered Health Services from a Network provider, you must notify the Claims Administrator. The Covered Health Services for which notification is required is shown in (Section 1: What's Covered--Benefits). When you notify the Claims Administrator, you will receive the Care Coordination services described above.

Designated Facilities and Other Providers

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

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

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You or your Network Physician must notify the Claims Administrator of special service needs (including, but not limited to, transplants or cancer treatment) that might warrant referral to a Designated Facility or non-Network facility or provider. If you do not notify the Claims Administrator in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Plan.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify the Claims Administrator, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

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

Limitations on Selection of Providers

If the Claims Administrator determines that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, you may be required to select a single Network Physician to provide and coordinate all future Covered Health Services.

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

If you don't make a selection within 31 days of the date we notify you, the Claims Administrator will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Non-Network Benefits

Depending on the geographic area and the service you receive, you may have access through the Claims Administrator's Shared Savings Program to providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, and if your Copayment is expressed as a percentage of Eligible Expenses for Non-Network Benefits, that percentage will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers, because the Eligible Expense may be a lesser amount.

Notification Requirement

You must notify the Claims Administrator before getting certain Covered Health Services from non-Network providers. The details are shown in the *Must You Notify the Claims Administrator?* column in (Section 1: What's Covered--Benefits). If you fail to notify the Claims Administrator, Benefits are reduced or denied.

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

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Care Coordination[SM]

When you notify the Claims Administrator as described above, they will work to implement the Care Coordination[SM] process and to provide you with information about additional services that are available to you, such as disease management programs, health education, pre-admission counseling and patient advocacy.

Emergency Health Services

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

Network Benefits are paid for Emergency Health Services, even if the services are provided by a non-Network provider.

If you are confined in a non-Network Hospital after you receive Emergency Health Services, the Claims Administrator must be notified within one business day or on the same day of admission if reasonably possible. The Claims Administrator may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date the Claims Administrator decides a transfer is medically appropriate, Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.

If you are admitted as an inpatient to a Network Hospital within 24 hours of receiving treatment for the same condition as an Emergency Health Service, you will not have to pay the Copayment for Emergency Health Services. The Copayment for an Inpatient Stay in a Network Hospital will apply instead.

Note: Please note that the Copayment for Emergency Health Services will not be waived if you have been placed in an observation bed for the purpose of monitoring your condition, rather than being admitted as an inpatient in the Hospital. In this case, the Emergency Copayment will apply instead of the Copayment for an Inpatient Stay.

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HealtheNotes[SM]

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

The Claims Administrator makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of Evidence Based Medicine (EBM) as described in Section 10, *Glossary* under the definition of Covered Health Services.

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

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

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Special Mental Health Programs and Services

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

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Section 4: When Coverage Begins

The Following Should be Noted:

This section includes information about:

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

How to Enroll

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

If You Are Hospitalized When Your Coverage Begins

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

You should notify the Claims Administrator within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network Providers.

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Who is Eligible for Coverage

Who	Description	Who Determines Eligibility
Eligible Person	Eligible Person usually refers to an employee of ours who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Participant. For a complete definition of Eligible Person and Participant, see (Section 10: Glossary of Defined Terms). If both Spouses are Eligible Persons under the Plan, each may enroll as a Participant or be covered as an Enrolled Dependent of the other, but not both. Except as we have described in (Section 4: When Coverage Begins), Eligible Persons may not enroll without employer representative signature on the enrollment application form.	We determine who is eligible to enroll under the Plan.
Dependent	Dependent generally refers to the Participant's Spouse and children. This also includes surviving dependents for up to 12 months. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see (Section 10: Glossary of Defined Terms). Qualified dependents of Early Retirees and Continuation of Coverage Participants – refer to Section 8 for additional information. Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Plan. If both parents of a Dependent child are enrolled as a Participant, only one parent may enroll the child as a Dependent.	We determine who qualifies as a Dependent.

Who	Description	Who Determines Eligibility
	Except as we have described in (Section 4: When Coverage Begins), Dependents may not enroll without employer representative signature on the enrollment application form.	

When to Enroll and When Coverage Begins

When to Enroll	Who Can Enroll	Begin Date
Initial Enrollment Period The Initial Enrollment Period is the first period of time when Eligible Persons can enroll.	Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the first date of active work (for a teacher under contract, the effective date of health coverage is the earliest of either the first day that students are expected to be in class or the first date of their paid employment contract), if the Plan Administrator receives the completed enrollment form and any required contribution for coverage within 31 days of the date the Eligible Person becomes eligible to enroll.
Open Enrollment Period	Eligible Persons may enroll themselves and their Dependents.	The Plan Administrator determines the Open Enrollment Period. Coverage begins on the date identified by the Plan Administrator once the Plan Administrator receives the online enrollment within the Open Enrollment period.
Late Enrollment	Eligible Persons may enroll themselves and their Dependents.	If you do not enroll for coverage within 30 days of the date eligible, you may enroll at a later time as a late enrollee, but only during the annual open enrollment period in May. Coverage will then become effective on July 1.
New Eligible Persons	New Eligible Persons may enroll themselves and their Dependents.	Coverage begins on the first date of active work if the Plan Administrator receives the properly completed enrollment form and any required contribution for coverage within 31 days of the date the new Eligible Person becomes eligible

When to Enroll	Who Can Enroll	Begin Date
		to enroll and if the Participant pays any required contribution to the Plan Administrator for Coverage.
Adding New Dependents	Participants may enroll Dependents who join their family because of any of the following events: • Birth. • Legal adoption. • Placement for adoption. • Marriage. • Court or administrative order. • Legal guardianship of a child (court document required).	Coverage begins on the date of the event if the Plan Administrator received the completed enrollment form and any required contribution for coverage within 31 days of the event that makes the new Dependent eligible. No coverage for newborn services unless the newborn is added to the plan within 31 days of birth. Dependents must be added by completing an enrollment form within 31 days of birth.
Special Enrollment Period An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis. An Eligible Person and/or Dependent does not need to elect	Changes (enrollment, termination or change) to your Health coverage can be made midyear only if preceded by a Life Event/Qualified Status Change, and the change is made within 31 days of the life event/qualified status change. Your benefits change must be consistent with your life event/qualified status change. The following events qualify you for a change in coverage: • Marriage • Divorce	**Event Takes Place** (for example, a birth or marriage). Coverage begins on the date of the event if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the event.

When to Enroll	Who Can Enroll	Begin Date
COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is elected.	• Legal separation • Birth or placement for adoption of a child • Death • Ineligibility of a dependent • Loss of other coverage (a certificate of creditable coverage as proof of lost coverage will be required) • Termination of employment • Change in your employment status or that of your spouse • Change in health coverage attributable to your employment or that of your spouse • A court order • Entitlement to Medicare or Medicaid	

A special enrollment period applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
  - Loss of eligibility (including, without limitation, legal separation, divorce or death).
  - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
  - In the case of COBRA continuation coverage, the coverage ended.
  - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
  - The Plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
  - termination of your or your Dependent's

Missed Initial Enrollment Period or Open Enrollment Period. Unless otherwise noted under the "Who Can Enroll" column, coverage begins on the day immediately following the day coverage under the prior plan ends if the Plan Administrator receives the completed enrollment form and any required contribution within 31 days of the date coverage under the prior plan ended.

When to Enroll	Who Can Enroll	Begin Date
	Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must notify the Plan Administrator within 60 days of termination); — you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must notify the Plan Administrator within 60 days of determination of subsidy eligibility);	

Section 5: How to File a Claim

The Following Should be Noted:

This section provides you with information about:

- How and when to file a claim.
- If you receive Covered Health Services from a Network provider, you do not have to file a claim. We pay these providers directly.
- If you receive Covered Health Services from a non-Network provider, you are responsible for filing a claim.

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact the Claims Administrator. However, you are responsible for meeting the Annual Deductible and for paying Copayments to a Network provider at the time of service, or when you receive a bill from the provider.

Filing a Claim for Benefits

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us

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through the Claims Administrator. You must file the claim in a format that contains all of the information required, as described below.

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

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

Pharmacy Benefit Claims

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

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

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Required Information

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

A. A Participant's name and address.
B. The patient's name, age and relationship to the Participant.
C. The member number stated on your ID card.
D. An itemized bill from your provider that includes the following:

- Patient Diagnosis
- Date(s) of service
- Procedure Code(s) and descriptions of service(s) rendered
- Charge for each service rendered
- Provider of service Name, Address and Tax Identification Number

E. The date the Injury or Sickness began.
F. A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

Payment of Benefits

You may not assign your Benefits under the Plan to a non-Network provider without our consent. The Claims Administrator may, however, in their discretion, pay a non-Network provider directly for services rendered to you.

The Claims Administrator will notify you if additional information is needed to process the claim. The Claims Administrator may request a one time extension not longer that 15 days and will pend your claim until all information is received. Once you are notified of the extension or missing information, you then have at least 45 days to provide this information.

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Benefit Determinations

Post-Service Claims

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

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

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

Pre-Service Claims

Pre-service claims are those claims that require notification or approval prior to receiving medical care. If your claim was a pre-service claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days after the pre-service claim was received. If additional information is needed to process the pre-service claim, the

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

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

Urgent Claims that Require Immediate Action

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

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

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

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

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

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

Concurrent Care Claims

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

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

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Section 6: Questions and Appeals

The Following Should be Noted:

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

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

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

What to Do First

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

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If you are appealing an urgent care claim denial, please refer to the "Urgent Claim Appeals that Require Immediate Action" section below and contact Customer Service immediately.

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

How to Appeal a Claim Decision

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

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

If your appeal is not received within this time period, the appeal is invalid.

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Appeal Process

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

In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, Plan Administrator will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-Service and Post-Service Claim Appeals

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

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

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

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

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

The Plan Administrator has the exclusive right to interpret and administer the Plan, and these decisions are conclusive and binding.

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

Urgent Claim Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

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- The appeal does not need to be submitted in writing. You or your Physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt by the Claims Administrator of your request for review of the determination taking into account the seriousness of your condition.

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

Federal External Review Program

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

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

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

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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. A request must be made within four months after the date you received Archdiocese of St Louis's decision.

An external review request should include all of the following:

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

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

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

Standard External Review

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

- a preliminary review by UnitedHealthcare of the request;

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

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

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

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

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

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

- all relevant medical records;

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

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

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

Expedited External Review

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

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

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

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

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

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

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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 Archdiocese of St Louis. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

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

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Section 7: Coordination of Benefits

The Following Should be Noted:

This section provides you with information about:

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

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Plan will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the National Association of Insurance Commissioners (NAIC) and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

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

The order of benefit determination rules described in this section determine which Coverage Plan will pay as the Primary Coverage Plan. The Primary Coverage Plan that pays first pays without regard to the possibility that another Coverage Plan may cover some expenses. A Secondary Coverage Plan pays after the Primary Coverage Plan and may reduce the benefits it pays. This is to prevent payments from all group Coverage Plans from exceeding 100 percent of the total Allowable Expense.

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Definitions

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

1. "Coverage Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Coverage Plan and there is no COB among those separate contracts.
   a. "Coverage Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or other governmental benefits, as permitted by law.
   b. "Coverage Plan" does not include: individual or family insurance; closed panel or other individual coverage (except for group-type coverage); school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.

   Each contract for coverage under a. or b. above is a separate Coverage Plan. If a Coverage Plan has two parts and COB

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rules apply only to one of the two, each of the parts is treated as a separate Coverage Plan.

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

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

3. "Allowable Expense" means a health care service or expense, including deductibles and copayments, that is covered at least in part by any of the Coverage Plans covering the person. When a Coverage Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Coverage Plans is not an Allowable Expense. Dental care, routine vision care, outpatient prescription drugs, and hearing aids are examples of expenses or services that are not Allowable Expenses under the Plan. The following are additional examples of expenses or services that are not Allowable Expenses:

   a. If a Covered Person is confined in a private Hospital room, the difference between the cost of a Semi-private Room in the Hospital and the private room, (unless the patient's stay in a private Hospital room is medically necessary in terms of generally accepted medical practice, or one of the Coverage Plans routinely provides coverage for Hospital private rooms) is not an Allowable Expense.

   b. If a person is covered by two or more Coverage Plans that compute their benefit payments on the basis of usual and

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customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

   c. If a person is covered by two or more Coverage Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

   d. If a person is covered by one Coverage Plan that calculates its benefits or services on the basis of usual and customary fees and another Coverage Plan that provides its benefits or services on the basis of negotiated fees, the Primary Coverage Plan's payment arrangements shall be the Allowable Expense for all Coverage Plans.

   e. The amount a benefit is reduced by the Primary Coverage Plan because a Covered Person does not comply with the Coverage Plan provisions. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.

4. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under this Coverage Plan, or before the date this COB provision or a similar provision takes effect.

5. "Closed Panel Plan" is a Coverage Plan that provides health benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Coverage Plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

6. "Custodial Parent" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

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Order of Benefit Determination Rules

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

A. The Primary Coverage Plan pays or provides its benefits as if the Secondary Coverage Plan or Coverage Plans did not exist.

B. A Coverage Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Coverage Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Coverage Plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Coverage Plan to provide out-of-network benefits.

C. A Coverage Plan may consider the benefits paid or provided by another Coverage Plan in determining its benefits only when it is secondary to that other Coverage Plan.

D. The first of the following rules that describes which Coverage Plan pays its benefits before another Coverage Plan is the rule to use.

1. Non-Dependent or Dependent. The Coverage Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the Coverage Plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Coverage Plan covering the person as a dependent; and primary to the Coverage Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Coverage Plans is reversed so that

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the Coverage Plan covering the person as an employee, member, subscriber or retiree is secondary and the other Coverage Plan is primary.

2. Child Covered Under More Than One Coverage Plan. The order of benefits when a child is covered by more than one Coverage Plan is:

a. The Primary Coverage Plan is the Coverage Plan of the parent whose birthday is earlier in the year if:

1) The parents are married;

2) The parents are not separated (whether or not they ever have been married); or

3) A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the Coverage Plan that covered either of the parents longer is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Coverage Plan of that parent has actual knowledge of those terms, that Coverage Plan is primary. This rule applies to claim determination periods or plan years commencing after the Coverage Plan is given notice of the court decree.

c. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

1) The Coverage Plan of the custodial parent;

2) The Coverage Plan of the Spouse of the custodial parent;

3) The Coverage Plan of the noncustodial parent; and then

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4) The Coverage Plan of the Spouse of the noncustodial parent.

3. Active or inactive employee. The Coverage Plan that covers a person as an employee who is neither laid off nor retired is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual as a retired worker and as a dependent of an actively working Spouse will be determined under the rule labeled D(1).
4. Continuation coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Coverage Plan, the Coverage Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Coverage Plan does not have this rule, and if, as a result, the Coverage Plans do not agree on the order of benefits, this rule is ignored.
5. Longer or shorter length of coverage. The Coverage Plan that covered the person as an employee, member, subscriber or retiree longer is primary.
6. If a husband or wife is covered under this Coverage Plan as a Participant and as an Enrolled Dependent, the dependent benefits will be coordinated as if they were provided under another Coverage Plan, this means the Participant's benefit will pay first.
7. If the preceding rules do not determine the Primary Coverage Plan, the Allowable Expenses shall be shared equally between the Coverage Plans meeting the definition of Coverage Plan under this provision. In addition, this Coverage Plan will not pay more than it would have paid had it been primary.

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Effect on the Benefits of this Plan

A. When this Coverage Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Coverage Plans during a claim determination period are not more than 100 percent of total Allowable Expenses. The difference between the benefit payments that this Coverage Plan would have paid had it been the Primary Coverage Plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the Covered Person and used by this Coverage Plan to pay any Allowable Expenses, not otherwise paid during the claim determination period. As each claim is submitted, this Coverage Plan will:

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine whether a benefit reserve has been recorded for the Covered Person; and
3. Determine whether there are any unpaid Allowable Expenses during that claims determination period.

If there is a benefit reserve, the Secondary Coverage Plan will use the Covered Person's benefit reserve to pay up to 100 percent of total Allowable Expenses incurred during the claims determination period. At the end of the claim determination period, the benefit reserve returns to zero. A new benefit reserve must be created for each new claim determination period.

A. When this Coverage Plan is secondary, it may reduce its benefits by the total amount of benefits paid or provided by all Coverage Plans primary to this Coverage Plan. As each claim is submitted, this Coverage Plan will:

1. Determine its obligation to pay or provide benefits under its contract;
2. Determine the difference between the benefit payments that this Coverage Plan would have paid had it been the Primary

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Coverage Plan and the benefit payments paid or provided by all Coverage Plans primary to this Coverage Plan.

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

B. If a Covered Person is enrolled in two or more closed panel Coverage Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Coverage Plan, COB shall not apply between that Coverage Plan and other closed panel Coverage Plans.

C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan (retired individuals and their Spouses who are 65 or over and who have met the Medicare entitlement requirements).

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

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

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Right to Receive and Release Needed Information

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

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

Payments Made

A payment made under another Coverage Plan may include an amount that should have been paid under this Coverage Plan. If it

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does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Coverage Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

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

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Section 8: When Coverage Ends

The Following Should be Noted:

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

- Events that cause coverage to end.
- The date your coverage ends.
- Extended coverage.
- Continuation of coverage.

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General Information about When Coverage Ends

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

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

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

An Enrolled Dependent's coverage ends on the date the Participant's coverage ends, except in cases of surviving Dependents and early retirement, or continuation of coverage, provided paperwork and premiums continue.

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Events Ending Your Coverage

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

Ending Event	What Happens
The Entire Plan Ends	Your coverage ends on the date the Plan ends. We are responsible for notifying you that your coverage has ended.
You Are No Longer Eligible	Your coverage ends on the date you are no longer eligible to be a Participant or Enrolled Dependent. Please refer to (Section 10: Glossary of Defined Terms) for a more complete definition of the terms "Eligible Person", "Participant", "Dependent" and "Enrolled Dependent". Your coverage ends if you cease active work. However, if you cease active work for the following reasons your Employer may continue your coverage for a limited time, provided you make any required contributions: • Injury, sickness or pregnancy – 6 months (or) • Temporary layoff - 3 months (or) • Approved leave of absence – 12 months
The Plan Administrator Receives Notice to End Coverage	Your coverage ends on the date the Plan Administrator receives written notice from the Participant or us instructing the Plan Administrator to end your coverage, or the date requested in the notice, if later.
Active Duty In the Armed Forces	Your coverage ends on the date you begin active duty in the Armed Forces of any Country.

Other Events Ending Your Coverage

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

Ending Event	What Happens
Fraud, Misrepresentation or False Information	The Participant commits an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include, but are not limited to, false information relating to another person's eligibility or status as a Dependent.
Threatening Behavior	You committed acts of physical or verbal abuse that pose a threat to our staff, the Claims Administrator's staff, a provider, or other Covered Persons.
Dependent Coverage Termination	Coverage for each Dependent terminates on the earliest date stated: • On the date the Dependent ceases to be an eligible Dependent (see Section 10 for definition of Dependent); or • On the date the Dependent becomes covered for personal benefits under this Plan; or • On the date the Dependent begins active duty in the Armed Forces of any country; or • On the date you request that coverage on your Dependent be terminated due to a special event or Open Enrollment, or • 12 months after the death of a covered Participant provided the Dependent is otherwise an eligible Dependent and required contributions are made. At the end of the 12 months (or earlier if the Dependent ceases to be an eligible Dependent), Continuation of Coverage may be applied for.

Coverage for a Handicapped Child

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

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

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

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

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

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

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Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the Participant's coverage under the Plan ends will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Plan was terminated.

Continuation of Coverage

You may continue medical, prescription and dental benefits (no life insurance) that are in force for you and/or your dependents upon the occurrence of certain events that would normally result in termination of coverage under the Plan.

Who May Continue Coverage, When, and for How Long?

A qualified Continuation of Coverage participant may receive the same benefits and choices such as the right to make changes during an open enrollment or other qualifying events within 31 days of the event. Notification to the Archdiocese of St. Louis Office of Human Resources at 314.792.7546 would be required in order to be approved by the Archdiocese.

Any individual who has been covered under this Plan for 3 months or longer may elect to continue coverage. Anyone who is covered under another group health care plan or Medicare is not eligible for this continuation of coverage. You may continue medical, dental and prescription coverage under the Plan for yourself and your dependents for up to 18 months if your

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coverage terminates for any of the following reasons:

- If your employment terminates for any reason other than your gross misconduct; or
- If your working hours are reduced and you are no longer considered eligible for coverage under the Plan.

Continuation coverage may extend from 18 months to 29 months for a participant and/or dependent who is disabled (as defined by the Social Security Administration) at the time of termination or reduction of hours, provided that such participant and/or dependent has given notice of the disability within 60 days of the Social Security determination and requested the extended continuation period before the end of the first 18 months.

Your dependents' coverage may be continued for up to 36 months if their coverage terminates for any of the following reasons:

- If you should die; or
- If you become divorced or legally separated from your spouse; or
- If you are no longer an active employee and you become eligible for Medicare; or
- If your dependent child no longer meets the definition of an eligible dependent child under the Plan.

When Continued Coverage Ends

The continued coverage will end for any person when:

- The cost of continued coverage is not paid on or before the date it is due; or

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- That person becomes entitled to Medicare; or
- That person is covered or becomes covered under another group health care plan that does not have a pre-existing condition limitation; or
- The Plan terminates for all employees; or
- That person has been in the continued coverage plan for applicable maximum time frame.

Coverage Change Due to a Qualifying Event

There are a limited number of qualifying events under the Continuation of Coverage Provision. You are eligible to change your coverage only when you experience one of the qualifying events listed below.

- Marriage
- Divorce/Legal Separation/Legal Annulment
- Death of Spouse/Dependent
- Dependent child reaches 26 years of age
- Dependent begins a new job
- Dependent loss of coverage
- Birth of a Child
- Legal Adoption/Placement of Adoption
- Court Order, Judgment, or Decree
- Medicare commences
- Significant coverage decrease
- Significant cost change 10% or more

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Notice Responsibilities

Within 60 days of termination or the qualifying event, it is your responsibility to notify the Archdiocesan Office of Human Resources at benefits@archstl.org or 314.792.7546 of whether or not you intend to enroll in the continued coverage provision plan.

It is your responsibility or that of your spouse to notify the Archdiocesan Office of Human Resources, if you become divorced or legally separated. It is your responsibility or that of your covered child to notify the Office of Human Resources if your dependent child no longer qualifies as a covered dependent under the Plan. If you, your spouse, or child, fail to properly notify the Office of Human Resources within the 60 day period, you, your spouse, or your dependent child will be unable to purchase continued coverage.

Cost of Continued Coverage

Any person who chooses to continue coverage under the Plan will be required to pay the entire cost of that coverage (including any portion you now pay and any portion your Employer now pays). Your payments for continued coverage must be made within 30 days after the initial election, and thereafter by the 18th of each month within the current billing month or your coverage will end. The individual must submit payment via automatic withdrawal for all premium charges on a timely basis. The health insurance plan will be terminated at the end of the month in the event of lack of payment for the month payment it is not received.

Schedule of Benefits for Continued Coverage

Medical and Prescription and dental benefits (no life insurance) will remain the same as the coverage in force for active employees. If you have any questions, please contact the Office of Human Resources at 314.792.7546 or benefits@archstl.org.

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

Early Retirees

Early Retirees who are enrolled in the Archdiocese Employee Benefits Plan, may continue full health coverage in the Plan until they are eligible for Medicare health insurance coverage.

If covered, dependent Spouses may continue coverage beyond the retired employee's date of Medicare eligibility under this early retiree health coverage provision until the earliest of five years from the date of retired employee's Medicare eligibility or their own (the Spouse's) Medicare eligibility.

If covered dependent children may continue coverage beyond the retired employee's date of Medicare eligibility under this provision until the earliest of: five years from the date of the retired employee's Medicare eligibility or the date that they reach 26 years of age.

Should a retiree obtain dependents and wish to convert from individual coverage to family coverage, the retiree would have thirty (30) days from the event (marriage/adoption/birth) to change coverage from single to family.

The employee will be responsible for paying 100% of the then current premium, plus any regular future premium increase, on a monthly basis unless they are eligible for Medicare. They will be responsible for the then current dependent premiums, plus any regular premium increases, on a monthly basis as long as the dependent(s) are eligible for coverage. The employee and/or their dependents would remain in the Plan and make premium payments via automatic withdrawal from a designated bank account. The employee should contact the Archdiocese Office of Human Resources for the necessary paperwork to enroll in the early retiree provision.

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

If a participant under the early retiree provision terminates coverage, he will not be eligible to reenroll in the plan at a later date.

If a retiree's former employer terminates participation with the Archdiocese Health Care Plan, the retiree's coverage with the Archdiocese will also terminate.

The eligibility requirements, availability, and the terms of the early retiree health care provisions are subject to change by the Archdiocese of St. Louis.

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Section 9: General Legal Provisions

The Following Should be Noted:

This section provides you with information about:
- General legal provisions concerning your Plan.

Plan Document

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

Relationship with Providers

The relationships between us, the Claims Administrator, and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Nor are they agents or employees of the Claims Administrator. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. The credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. Network providers are not our

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

employees or employees of the Claims Administrator; nor do we have any other relationship with Network providers such as principal-agent or joint venture. Neither we nor the Claims Administrator are liable for any act or omission of any provider.

The Claims Administrator 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.

We and the Plan Administrator are solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of Benefits.
- 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.

- You are responsible for choosing your own provider.
- You 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.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and us is that of employer and employee, Dependent or other classification as defined in the Plan.

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Incentives to Providers

The Claims Administrator pays Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

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

The methods used to pay specific Network providers may vary. 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 at the telephone number on your ID card. They 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.

Incentives to You

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

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

Interpretation of Benefits

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

- Interpret Benefits under the Plan.
- Interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and Amendments.
- Make factual determinations related to the Plan and its Benefits.

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

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

Administrative Services

We may, in our sole discretion, arrange for various persons or entities to provide administrative services in regard to the Plan, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time in our sole discretion. We are not required to give you prior

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

notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Plan

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

Any provision of the Plan which, on its effective date, is in conflict with the requirements of federal statutes or regulations, or applicable state law provisions (of the jurisdiction in which the Plan is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

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

Clerical Error

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

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

Information and Records

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

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

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

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

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

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

Examination of Covered Persons

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

Workers' Compensation not Affected

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

Medicare Eligibility

This Plan is primary and will pay benefits before Medicare does for Eligible Persons who are entitled to Medicare on the basis of disability and who are covered under the Plan by virtue of their own or a family member's current employment status with an employer who maintains the Plan.

The Plan is also primary to Medicare throughout the first 18 months of end stage renal disease ("ESRD") – based Medicare eligibility or entitlement.

Federal Legislation provides that Eligible Persons, age 65 and over, who have current employment status may elect to opt out of the

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

Plan and elect Medicare coverage. If an Eligible Person opts out of this Plan no benefits will be paid by the Plan. If an affected Employee elects the benefits of this Plan as primary, the Plan will provide benefits equal to the benefits available to individuals under age 65. If the employee opts out of the Plan, no benefits will be available under this Plan. Benefits under the Plan are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Plan.

Refund of Overpayments

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

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Plan.

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

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, 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. We may have other rights in addition to the right to reduce future benefits.

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Limitation of Action

If you want to bring a legal action against us or the Claims Administrator you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against us or the Claims Administrator.

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

NOTICE OF PRIVACY PRACTICES FOR THE ARCHDIOCESE OF ST. LOUIS UNITEDHEALTHCARE CHOICE PLUS STANDARD PLAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

DEFINITIONS:

Covered Entity: An entity subject to the regulations enacted under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including health care providers who transmit health information in an electronic form, health plans, and health care clearinghouses. The Plan is a Covered Entity.

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Health Care Operations: Activities that include, but are not limited to, any of the following activities of the Plan to the extent that the activities are related to Plan functions:

- Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives, and related functions that do not include treatment;
- Reviewing the competence of health care professionals and their performance, including accreditation, certification, licensing, or credentialing activities;
- Underwriting, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and surrendering, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance);
- Conducting or arranging medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement methods of payment or coverage policies; and
- Business management and general administrative activities of the Plan, such as

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— management activities relating to implementation of and compliance with HIPAA's administrative simplification requirements;

— customer service, including provision of data analysis for policy holders, plan sponsors, or other customers, provided that PHI is not disclosed to such policy holder, plan sponsor, or customer;

— resolution of internal grievances; and

— due diligence related to the sale, transfer, merger of the Plan to, or consolidation of all or part of the Plan with another Covered Entity, or an entity that following such activity will become a Covered Entity.

HIPAA: The Health Insurance Portability and Accountability Act of 1996.

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

- Is created or received by a health care provider, health plan, employer, or health care clearinghouse, and
- Relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and
  - — that identifies the Participant; or
  - — with respect to which there is a reasonable basis to believe the information can be used to identify the Participant.

Organized Health Care Arrangement: A group health plan and one or more other group health plans, each of which are maintained

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by the same plan sponsor; and health insurance issuers or HMOs with respect to such group health plans, but only with respect to PHI created or received by such health insurance issuers or HMOs that relates to individuals who are or have been Participants or beneficiaries of such group health plans.

Payment: The activities undertaken by the Plan to obtain premiums or to determine or fulfill the Plan's responsibility for coverage and provision of benefits. These activities relate to the Participant to whom health care is provided. They include, but are not limited to:

- Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
- Risk adjusting amounts due based on Participant health status and demographic characteristics;
- Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess loss insurance), and related health care data processing;
- Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
- Utilization review activities, including precertification and pre-authorization of services, concurrent and retrospective review of services; and
- Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement:
  - — name and address;
  - — date of birth;

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— social security number;

— payment history;

— account number; and

— name and address of the health care provider and/or health plan.

Plan Sponsor: For purposes of NOTICE OF PRIVACY PRACTICES FOR THE ARCHDIOCESE OF ST. LOUIS UNITEDHEALTHCARE CHOICE PLUS STANDARD PLAN, the Archdiocese of St. Louis.

Protected Health Information ("PHI"): Individually Identifiable Health Information that is transmitted or maintained in any form or medium. PHI does not include educational records covered by the Family Educational Rights and Privacy Act or employment records held by a Covered Entity in its role as employer.

Regulations: The Standards for Privacy of Individually Identifiable Health Information enacted in accordance with HIPAA at 45 Code of Federal Regulations (CFR) Parts 160 and 164, as amended from time to time.

Secretary: The Secretary of the Department of Health and Human Services.

Treatment: The provision, coordination, or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your health care providers.

General Provisions.

The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Except as otherwise provided in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

Use and Disclosure of PHI as Required by Law. The Plan will use and disclose PHI as required by federal and state law, including uses and disclosures required by the Secretary to investigate or determine the Plan's compliance with privacy regulations.

Plan Sponsor. For purposes of this Section 8, the Archdiocese of St. Louis is the Plan Sponsor of this Plan. The Plan will disclose PHI to the Plan Sponsor or an Employer only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions contained in this Section 8.

Duties of Plan Sponsor. The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by a Participant;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor, other than (if otherwise permissible under applicable state law) a health plan that is part of an Organized Health Care Arrangement which includes the Plan, unless authorized by a Participant;

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- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for herein of which it becomes aware;
- make PHI available to a Participant in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for the purpose of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Separation Between Plan and Plan Sponsor. In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- with respect to the Plan Sponsor, employees in the Office of Human Resources; and
- with respect to the Employer, those persons designated to perform human resources functions.

Limitations of PHI Access and Disclosure. The persons described in the paragraph above entitled Separation Between Plan and Plan Sponsor may only have access to and use and disclose PHI for plan administrative functions that the Plan Sponsor performs for the Plan.

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Noncompliance Issues. If the persons described in the paragraph above entitled Separation Between Plan and Plan Sponsor do not comply with this Plan, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations.

The Plan and its business associates (companies who help the Plan provide you with your benefits, such as outside administrators) will use PHI without your consent, authorization, or opportunity to agree or object to carry out three activities: Treatment, Payment, and Health Care Operations. The Plan will also disclose PHI to the Plan Administrator for purposes related to those activities. The Plan Administrator has amended the plan document to protect your PHI as required by federal law.

Treatment. The Plan may disclose PHI to your health care providers (such as physicians and hospitals) for purposes of Treatment. However, PHI that consists of psychotherapy notes will not be used or disclosed without your written authorization, even if for treatment purposes, unless it is necessary to defend the Plan in litigation filed by you.

For example, the Plan may disclose to a treating specialist the name of your general practitioner so that the specialist may ask for your treatment records from the general practitioner.

Payment. The Plan may use or disclose your PHI for purposes of Payment.

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For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health Care Operations. The Plan may use or disclose PHI for Health Care Operations.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs, or audit the accuracy of the way it processes claims.

Uses and Disclosures Which Require That You Be Given an Opportunity to Agree or Object.

Disclosure of your PHI to the following persons is allowed if you have either agreed to the disclosure or have been given the opportunity to object and have not objected: (1) your family members or close personal friends if the information is directly relevant to the family member's or friend's involvement with your care or payment for that care; or (2) disaster relief organizations for purposes of notifying friends and family members involved in your care of your location or condition in the event of an emergency. If you are not present to voice your agreement or objection, the Plan may disclose PHI to such persons that is relevant to their involvement with your care if the Plan determines that it is in your best interests.

Uses and Disclosures For Which Consent, Authorization, or Opportunity to Object is Not Required.

The Plan is allowed to sue and disclose your PHI *without* your consent, authorization, or opportunity to object under the following circumstances:

When Required By Law. For example, when needed to comply with Medicare regulations.

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Public Health Activities. When permitted for purposes of public health activities such as preventing or controlling disease, or reporting disease or infection exposure.

Abuse and Neglect. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities, if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence.

Public Oversight. Where requested by a public oversight agency for oversight activities authorized by law.

Legal Proceedings. When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met.

Law Enforcement. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, subject to conditions contained in the HIPAA regulations.

Coroner, Medical Examiner, or Funeral Director. When required to be given to a coroner or medical examiner to identify a deceased person or determine a cause of death. The Plan may also disclose PHI to funeral directors to carry out their duties with respect to a deceased person.

Organ Donation. For assisting organizations involved in procuring, banking, or transplanting organs or tissue for the purpose of facilitating organ or tissue donation and transplantation.

Research. For research purposes, subject to conditions contained in the HIPAA regulations.

National Security. Where necessary to prevent a serious and imminent threat to the health or safety of a person or the public or

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for national security or intelligence purposes, if the disclosure is consistent with applicable law and standards of ethical conduct.

Workers' Compensation. When authorized by and to the extent necessary to comply with workers' compensation or similar laws.

To The Plan Sponsor. The Plan may disclose PHI to the Plan Sponsor to assist the Plan in providing you with your benefits.

Your Rights.

The HIPAA regulations entitle you to certain rights with regard to your PHI. Note that you may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you.

Right to Request Restrictions on PHI Uses and Disclosures. You may request that the Plan restrict uses and disclosures of your PHI to carry out Treatment, Payment, or Health Care Operations. You may also request that the Plan restrict disclosures to a disaster relief organization, or to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. You or your personal representative will be required to request restrictions on these uses and disclosures in writing.

Right to Request Confidential Communications. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if you clearly state to the Plan that the disclosure could endanger you. For example, you may request that your PHI be sent to your office address instead of your home address, if you feel that someone at your home who might receive your PHI through the mailing could threaten your safety.

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Right to Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI from the Plan that is used to make decisions about your benefits, such as enrollment, billing, claims, or medical management records. If access is denied, you or your personal representative will be provided with a written denial setting forth the reason for the denial, a description of how you may exercise your review rights, and a description of how you may complain to the Secretary of HHS. The Plan will respond to your request within the time required by state or federal law. Your request for access must be in writing.

Right to Amend PHI. You have the right to request that the Plan amend your PHI if you believe it is inaccurate or incomplete. If your request is denied in whole or in part, the Plan must provide you with a written denial that explains the reason for the denial. You or your personal representative may then submit a written statement disagreeing with the denial. Your statement will be included with any future disclosures of your PHI. The Plan will respond to your request within the time required by state or federal law. Your request for an amendment must be in writing. You must also include a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures. Upon your written request to the Plan, the Plan will provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting does not need to include PHI disclosures made:

- prior to the effective date of this Notice;
- to carry out Treatment, Payment, or Health Care Operations;
- to you about your own PHI;
- incident to a sue or disclosure otherwise permitted by the HIPAA regulations; or

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- based on your written authorization.

The Plan will respond to your request within the time required by state or federal law. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Right to Receive a Paper Copy of This Notice Upon Request. You have the right to obtain an additional paper copy of this Notice.

Right to File a Complaint With the Plan or the Secretary of HHS. In addition to filing a complaint with the Plan (see contact address below), you may also file a complaint with the Secretary at the following address:

Region VI, Office for Civil Rights, U.S. Department of HHS

601 East 12th Street

Room 248

Kansas City, Missouri 64106

The Plan will not retaliate against you for filing a complaint.

The Plan's Duties.

The Plan is required by law to maintain the privacy of PHI and to provide participants with notice of its legal duties and privacy practices. This Notice is effective beginning April 14, 2003, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to all of the PHI it maintains. If a privacy practice is changed in a way that affects you, a revised version of this Notice will be provided within 60 days.

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Who to Contact at the Plan to Exercise Your Rights or For More Information.

If you wish to exercise any of your rights described in this Notice, file a complaint with the Plan, or have any questions regarding this Notice or the subjects addressed in it, you may contact the following person:

Michael Puetz

Archdiocese of St. Louis

20 Archbishop May Drive

St. Louis, Missouri 63119

(314) 792-7540

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Section 10: Glossary of Defined Terms

The Following Should be Noted:

This section:

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

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.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

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

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when signed by us or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that are specifically amended.

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

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

Any amount you pay for medical expenses in the last three months of the previous calendar year, that is applied to the previous Annual Deductible, will be carried over and applied to the current Annual Deductible. This carry-over feature applies only to the individual Annual Deductible.

Autism Spectrum Disorders – a group of neurobiological disorders that includes *Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and a Pervasive Development Disorders Not Otherwise Specified (PDDNOS).*

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

Cancer Resource Services Program - the program made available by the Plan Sponsor to Participants. The Cancer Resource Services Program provides information to Participants or their Enrolled Dependents with cancer and offers access to additional cancer centers for the treatment of cancer.

Claims Administrator - the company (including its affiliates) that provides certain claim administration services for the Plan.

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

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Continuous Creditable Coverage - health care coverage under any of the types of plans listed below, during which there was no break in coverage of 63 consecutive days or more:

- A group health plan.
- Health insurance coverage.
- Medicare.
- Medicaid.
- Medical and dental care for members and certain former members of the uniformed services, and for their dependents.
- A medical care program of the Indian Health Services Program or a tribal organization.
- A state health benefits risk pool.
- The Federal Employees Health Benefits Program.
- Any public health benefit program provided by a state, county, or other political subdivision of a state.
- The State Children's Health Insurance Program (S-CHIP).
- Health plans established and maintained by foreign governments or political subdivisions and by the U.S. government.
- Any health coverage provided by a governmental entity.
- A health benefit plan under the Peace Corps Act.

A waiting period for health care coverage will be included in the period of time counted as Continuous Creditable Coverage.

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

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

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator on our behalf.

Covered Health Service(s) -those health services provided for the purpose of preventing, diagnosing or treating a Sickness, Injury, Mental Illness, Substance Use Disorder, or their symptoms.

A Covered Health Service is a health care service or supply described in (Section 1: What's Covered--Benefits) as a Covered Health Service, which is not excluded under (Section 2: What's Not Covered--Exclusions).

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

Custodial Care - services that:

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

Dependent - the Participant's legal Spouse or a married or unmarried child of the Participant or the Participant's Spouse who has not yet attained their 26th birthday, regardless of student status. The term child includes any of the following:

- A natural child.

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- A stepchild.
- A legally adopted child.
- A child placed in legal guardianship
- A child placed for adoption.
- A foster child who resides in your household in a regular parent-child relationship and qualifies as your exemption under the Internal Revenue Code.

The Participant must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions. A Dependent also includes a child for whom health care coverage is required through a 'Qualified Medical Child Support Order' or other court or administrative order. We are responsible for determining if an order meets the criteria of a Qualified Medical Child Support Order.

A spouse is the person to whom the Participant is married as recognized by the laws of the Catholic Church or the laws of the State of Missouri. It is always understood for this purpose that the spouse is of the opposite sex.

No coverage for newborn services unless the newborn is added to the plan within 31 days of birth. Dependents must be added by completing an enrollment form within 31 days of birth.

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

Designated Facility - a facility that has entered into an agreement on behalf of the facility and its affiliated staff with the Claims Administrator or with an organization contracting on its behalf, to render Covered Health Services for the treatment of specified

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

diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

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

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

Early Retirees – A Participant who meets the following eligibility requirements:

- Age 55 or older.
- Not yet eligible for Medicare.
- Employee must have been considered an active employee (working at least the equivalency of 1,000 hours or amore annually, teachers under contract must be ½ time or more).
- Employment must have been with a parish, school, or agency of the Archdiocese of St. Louis or a private Catholic organization with Archdiocese health care coverage.

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

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

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

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from non-Network providers, Eligible Expenses are determined, at the Claims Administrator's discretion, based on:
  - Available data resources of competitive fees in that geographic area.
  - Fee(s) that are negotiated with the provider.
  - 50% of the billed charge.
  - A fee schedule that the Claims Administrator develops.
- When Covered Health Services are received from Network providers, Eligible Expenses are the contracted fee(s) with that provider.

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

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that the Claims Administrator accepts.

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Eligible Person – you and your dependents can be eligible to receive benefits under this Plan on your first date of employment. To be eligible, you must be:

- Permanent Deacon fulfilling on of the following criteria: employee working less than 1,000 hours annually for an Archdiocesan Parish or Organization. Permanent Deacon must pay 100% of the premium for coverage or,
- A religious order priest, brother or sister who is an employee on official assignment with the Archdiocese (no annual hours worked requirement),
- A Kenrick-Glennon Seminarian, studying for the Archdiocese of St. Louis priesthood, who is not eligible for other group coverage,

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- A teacher with a ½ time or more contract,
- Permanent Deacon fulfilling one of the following criteria:

  — employee working less than 1,000 hours annually for any Archdiocesan Parish\Organization employer. Permanent Deacon must pay 100% of the premium for coverage or

  — non paid Permanent Deacon who is providing service to a parish or Archdiocesan organization. The Permanent Deacon must pay 100% of the premium for coverage under the plan.

  Note: Permanent Deacon who are active employees at a parish or Archdiocesan organization working over 1,000 hours annually are regular employees eligible for employer contributions for health insurance coverage.

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

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

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

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

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services,

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technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make 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.)
- 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:

- Life-Threatening Sickness or Condition. If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we 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, and that the service would be provided under standards equivalent to those defined by the *National Institutes of Health.*

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

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

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

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

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

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

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

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

Intensive Outpatient Treatment - a structured outpatient Mental Health or Substance 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.

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

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

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

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

Network Benefits - Benefits for Covered Health Services that are provided by (or directed by) a Network Physician or other Network provider in the provider's office or at a Network or non-Network facility.

Non-Network Benefits - Benefits for Covered Health Services that are provided by or directed by a non-Network Physician either at a Network facility or at a non-Network facility.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Plan. We and the Plan Administrator will agree upon the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - the maximum amount of Copayments you pay every calendar year. If you use both Network Benefits and Non-Network Benefits, two separate Out-of-Pocket Maximums apply. Once you reach the Out-of-Pocket Maximum for Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year. Once you reach the Out-of-Pocket Maximum for Non-Network Benefits, Benefits for those Covered Health Services that apply to the Out-of-Pocket Maximum are payable at 100% of Eligible Expenses during the rest of that calendar year. Copayments for some Covered Health Services will never apply to the Out-of-Pocket Maximum, as specified in (Section 1: What's Covered--Benefits) and those Benefits will never be payable at 100% even when the Out-of-Pocket Maximum is reached.

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

- Any charges for non-Covered Health Services.
- Copayments for Covered Health Services available by an optional Rider.
- The amount of any reduced Benefits if you don't notify the Claims Administrator as described in (Section 1: What's Covered--Benefits) under the *Must You Notify the Claims Administrator?* column.
- Charges that exceed Eligible Expenses.
- Any Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that do not apply to the Out-of-Pocket Maximum.
- The Annual Deductible.

Even when the Out-of-Pocket Maximum has been reached, you will still be required to pay:

- Any charges for non-Covered Health Services.
- Charges that exceed Eligible Expenses.
- The amount of any reduced Benefits if you don't notify the Claims Administrator as described in (Section 1: What's Covered--Benefits) under the *Must You Notify the Claims Administrator?* column.
- Copayments for Covered Health Services available by an optional Rider.
- Copayments for Covered Health Services in (Section 1: What's Covered--Benefits) that are subject to Copayments that do not apply to the Out-of-Pocket Maximum.

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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.

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

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

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan - Choice Plus Standard Plan for Archdiocese of St. Louis Health Benefit Plan.

Plan Administrator - is Archdiocesan Benefits Council (per First Amendment).

Plan Sponsor - Archdiocese of St. Louis. References to "we", "us", and "our" throughout the SPD refer to the Plan Sponsor.

Preexisting Condition - an Injury or Sickness that is identified by the Plan Administrator as having been diagnosed or treated, or for which prescription medications or drugs were prescribed or taken within the three month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Plan or, if earlier, the first day of any waiting period under the Plan.) A Preexisting Condition does not include Pregnancy. Genetic information is not an indicator of a Preexisting Condition, if there is not a diagnosis of a condition related to the genetic information.

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Pregnancy - includes all of the following:

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

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.
- 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.

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

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

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

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. The Claims Administrator will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. The Claims Administrator does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When the Claims Administrator uses the Shared Savings Program to pay a claim, patient responsibility is limited to Copayments calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

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

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

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

Spouse – the person to whom the Participant is married as recognized by the laws of the Catholic Church or the laws of the State of Missouri. It is always understood for this purpose that the spouse is of the opposite sex.

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

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

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an

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alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

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

Total Disability or Totally Disabled - a Participant's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

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

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)
- Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research, based on well-conducted randomized trials or cohort studies, as described.

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

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Riders, Amendments, Notices

Outpatient Prescription Drug Rider

Attachment I:

Women's Health and Cancer Rights Act of 1998

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

Family and Medical Leave Act of 1993 (FMLA)

Medicare Prescription Drug Improvement and Modernization Act of 2003 (Medicare D)

Patient Protection and Affordable Care Act ("PPACA")

Archdiocese of St. Louis

Outpatient Prescription Drug Rider

For UnitedHealthcare Choice Plus Standard Plan

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Outpatient Prescription Drug Rider

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

Benefits are provided for outpatient Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy.

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

NOTE: The Coordination of Benefits provision described in Section 7, *Coordination of Benefits (COB)* applies to covered Prescription Drugs as described in this section. Benefits for Prescription Drugs will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

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Introduction

Coverage Policies and Guidelines

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

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

Identification Card (ID Card) - Network Pharmacy

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

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

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

Designated Pharmacies

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

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, Non-Network Benefits will apply for that Specialty Prescription Drug.

Please see the Prescription Drug Rider Glossary for definitions of Specialty Prescription Drug and Designated Pharmacy. Refer to the heading *Supply Limits* within the Prescription Drug Rider for details on Specialty Prescription Drug supply limits.

Limitation on Selection of Pharmacies

If we determine that you are using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you

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don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

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

Coupons and Incentives

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

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

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

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

Benefits for Outpatient Prescription Drug Products

Benefits for outpatient Prescription Drug Products are available when the outpatient Prescription Drug Product meets the definition of a Covered Health Service.

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When a Brand Name Drug Becomes Available as a Generic

When a Prescription Drug Product becomes available as a Generic, the Brand-name version may no longer be available on the Preferred Drug List, and your Copayment may change.

You will either pay the Generic Copayment, if you choose to receive the Generic drug, or you may pay the higher Copayment for a Brand-name Prescription Drug Product which is not on the Preferred Drug List, if you choose to continue receiving the Brand-name or if your Physician determines that you should continue receiving the Brand-name.

The terms "generic" and "brand-name" are used in the health care industry in many different ways. To be sure that you know whether a drug is classified as Brand-name or Generic by use, please review the definitions contained in *Section 3: Glossary of Defined Terms* at the end of this Rider. You should also check the current classification on the Preferred Drug List through the Internet at www.myuhc.com or www.365wellst.com or by calling the telephone number on your ID care.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description of Pharmacy Type and Supply Limits" column of the *Benefit Information* table. For a single Copayment, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that the Claims Administrator has developed. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply.

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You may obtain a current list of Prescription Drug Products that have been assigned maximum quantity levels for dispensing through the Internet at www.myuhc.com or www.365wellst.com or by calling the telephone number on your ID card. The list is subject to periodic review and modification.

Notification Requirements

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

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

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

Non-Network Pharmacy Notification. When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for notifying the Claims Administrator as required.

The list of Prescription Drug Products requiring notification is subject to periodic review and modification. You may obtain a current list of Prescription Drug Products that require notification through the Internet at www.myuhc.com or www.365wellst.com or by calling the telephone number on your ID card.

If the Claims Administrator is not notified before the Prescription Drug Product is dispensed, you can ask us to consider

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reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. The contracted pharmacy reimbursement rates (the Prescription Drug Cost) will not be available to you at a non-Network Pharmacy. You may seek reimbursement as described in the Summary Plan Description (Section 5: How to File a Claim).

When you submit a claim on this basis, you may pay more because you did not notify the Claims Administrator before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Cost (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment.

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

What You Must Pay

You are responsible for paying the applicable Copayment described in the *Benefit Information* table when Prescription Drug Products are obtained from a retail or mail service Pharmacy.

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

- Copayments for Prescription Drug Products.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Cost) will not be available to you.

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Payment Information

Payment Term	Description	Amounts
Copayment	Copayments for a Prescription Drug Product at a Network Pharmacy can be either a specific dollar amount or a percentage of the Prescription Drug Cost. Copayments for a Prescription Drug Product at a non-Network Pharmacy can be either a specific dollar amount or a percentage of the Predominant Reimbursement Rate.	For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug Product. For Prescription Drug Products at a mail service Network Pharmacy, you are responsible for paying the lower of: • The applicable Copayment or • The Prescription Drug Cost for that Prescription Drug Product. ***See the Copayments stated in the Benefit Information table for amounts.***

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
Prescription Drugs from a Retail Network Pharmacy Benefits for outpatient Prescription Drug Products dispensed by a retail Network pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.	\$10 per Prescription Order or Refill for a **Generic Prescription Drug Product.** \$35 per Prescription Order or Refill for a **Brand-name Prescription Drug Product on the Preferred Drug List.** \$50 per Prescription Order or Refill for a **Brand-name Prescription Drug Product which is not on the Preferred Drug List.**
Prescription Drugs from a Retail Non-Network Pharmacy Benefits for outpatient Prescription Drug Products dispensed by a retail non-Network Pharmacy. If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your Summary Plan Description. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for that Prescription Drug Product. We will not reimburse you for any non-covered drug product. In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy. The following supply limits apply:	\$10 per Prescription Order or Refill for a **Generic Prescription Drug Product.** \$35 per Prescription Order or Refill for a **Brand-name Prescription Drug Product on the Preferred Drug List.** \$50 per Prescription Order or Refill for a **Brand-name Prescription Drug Product which is not on the Preferred Drug List.**

Description of Pharmacy Type and Supply Limits	Your Copayment Amount
• As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits.	
Prescription Drug Products from a Mail Service Network Pharmacy Benefits for outpatient Prescription Drug Products dispensed by a mail service Network Pharmacy. The following supply limits apply: • As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. To receive the maximum Benefit, you should ask your provider to write your Prescription Order or Refill for the full 90 days.	**For up to a 90 day supply, your Copayment is:** $20 per Prescription Order or Refill for a **Generic Prescription Drug Product.** $70 per Prescription Order or Refill for a **Brand-name Prescription Drug Product on the Preferred Drug List.** $100 per Prescription Order or Refill for a **Brand-name Prescription Drug Product which is not on the Preferred Drug List.**

Section 2: What's Not Covered--Exclusions

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

1. Coverage for Prescription Drug Products for the amount dispensed (days supply or quantity limit) which exceeds the supply limit.
2. Drugs which are prescribed, dispensed or intended for use while you are an inpatient in a Hospital, Skilled Nursing Facility, or Alternate Facility.
3. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental.
4. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
5. Prescription Drug Products for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

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6. Any product dispensed for the purpose of appetite suppression and other weight loss products.
7. A specialty medication Prescription Drug Product (such as immunizations and allergy serum) which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
8. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
9. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
10. Unit dose packaging of Prescription Drug Products.
11. Medications used for cosmetic purposes.
12. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that are determined to not be a Covered Health Service.
13. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
14. Treatment for toenail Onychomycosis (toenail fungus).
15. Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
16. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed. Any Prescription Drug Product that is therapeutically equivalent to an over-the-counter drug. Prescription Drug Products that are comprised of components that are available in over-the-counter form or equivalent, except as required to treat symptoms related to viral infections causing the common cold.

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17. New Prescription Drug Products and/or new dosage forms until the date they are reviewed by our Pharmacy and Therapeutics Committee and approved by our Preferred Drug List Management Committee.
18. Oral Contraceptives are not covered. Exceptions for anovulatory hormonal agent drugs prescribed by a physician with a medical diagnosis other than contraception should be directed to the Archdiocesan Office of Human Resources at (314) 792-7540.
19. Injections, patches, supplies or other prescription drugs for contraceptive purposes.
20. Mifeprex or other abortion pills.
21. Methotrexate (Brand name: Trexall, Folex, Rheumatrix, and Amethopterin, MTX and Methotrexate Sodium) and Misoprostol (Brand name Cytotec) except for medical diagnosis other than abortion. Exceptions for Methotrexate and Misoprostol for a medical diagnosis other than abortion should be directed to the Archdiocesan Office of Human Resources at 314-792-7540.

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Section 3: Glossary of Defined Terms

This section:

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

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product. A Prescription Drug Product is classified as a Brand-name based on available data resources, such as First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Designated Pharmacy – a pharmacy that has entered into an agreement with the Claims Administrator or with an organization contracting on its behalf, to provide specific Prescription Drug Products 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 Product: (1) that is chemically equivalent to a Brand-name drug; or (2) that we identify as a Generic product. Classification of a Prescription Drug Product as a Generic

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is determined by us and not by the manufacturer or pharmacy. A Prescription Drug Product is classified as a Generic based on available data resources, such as First DataBank, that classify drugs as either brand or generic based on a number of factors. You should known that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Network Pharmacy - a pharmacy that has:

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

A Network Pharmacy can be either a retail or a mail service pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the FDA, and ending on the earlier of the following dates:

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

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for

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a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and sales tax. We calculate the Predominant Reimbursement Rate using the Prescription Drug Cost that applies for that particular Prescription Drug Product at most Network Pharmacies.

Preferred Drug List - a list that identifies those Prescription Drug Products which are preferred by us for dispensing to Covered Persons when appropriate. This list is subject to our periodic (at least quarterly) review and modification. Contact the Claims Administrator at the telephone number on your ID card to obtain a copy of the current Preferred Drug List or you can access it through the Internet at www.myuhc.com or www.365wellst.com.

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

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

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

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Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Select Prescription Drug – a Prescription Drug that is generally a tier-3 drug with lower-tiered alternatives used to treat the same condition. For more information, visit **myuhc.com** or call the Claims Administrator at the toll-free number on your ID card.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties.

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Attachment I:

Women's Health and Cancer Rights Act of 1998

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

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

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- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

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

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

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (*e.g.*, your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-

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of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

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Family and Medical Leave Act of 1993 (FMLA)

FMLA requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for certain family and medical reasons. Employees are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles.

Reasons for Taking Leave:

Unpaid leave must be granted for any of the following reasons:

- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's Spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

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Job Benefits and Protection:

- For the duration of FMLA leave, the employer must maintain the employee's health coverage during the leave period just as though the employee had continued working.
- Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
- The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Please contact your employer for additional special information and whether or not you qualify for the Family Medical Leave Act of 1993.

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Medicare Prescription Drug Improvement and Modernization Act of 2003 (Medicare D)

Beginning January 1, 2006 Medicare prescription drug coverage became available to everyone covered by Medicare. This new Medicare prescription drug benefit is called Medicare Part D. If you

- Are eligible for Medicare Part D and
- You go 63 days or longer after the end of your first enrollment period without prescription drug coverage that is at least as good as Medicare Part D coverage,

Your monthly Part D premium will go up at least 1% per month for every month after the end of your first enrollment period during which you did not have prescription drug coverage that was at least as good as Medicare Part D coverage. For example, if you go nineteen months without coverage, your Part D premium will always be at least 19% higher than the premium most people pay. You will have to pay this higher premium as long as you have Medicare coverage.

Because the current coverage under the Mercy Health Plans option of the Archdiocese Plan is at least as good as the coverage under

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Medicare Part D, Plan participants who also have Medicare coverage can keep their current coverage without enrolling in Medicare Part D and not pay extra when they later decide to enroll in Medicare Part D.

You can keep your current coverage even if you choose to enroll in a Medicare prescription drug plan. However, if you decide to enroll in a Medicare prescription drug plan and drop your coverage under the Archdiocese Plan (prescription coverage included), you may not be able to get back your coverage under the Archdiocese Plan until the next annual open enrollment period. If you are a Medicare recipient and you drop or lose your coverage under the Archdiocese Plan and you go 63 days or longer without prescription drug coverage, you will be required to pay the higher premiums described above when you later enroll in Medicare Part D.

You may get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program.
- Call 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

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